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California Board of Registered Nursing RN Employer Survey

Final Report

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California Board of Registered Nursing
RN Employer Survey

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Executive Summary

Key Purposes

The key purposes of the RN Employer Survey were: "to identify difficulties in recruiting and retaining RNs, best practices that have resulted in reduction of nurse workforce issues, recommendations for changes needed to resolve nursing workforce issues and current conditions and issues."

The study participants were chief nursing officers or directors of nursing from 177 hospitals, 155 skilled nursing facilities, 39 public health agencies, and 119 home health agencies (N=490 of 1194 surveys sent; 41% response rate).

Shortage of RNs

- The statewide hospital RN vacancy rate at the time of the survey was 11% on average (range, 0% to 35%).
- Over 75% of hospitals relied on both RN travelers and agency nurses for some portion of RN coverage.
- Agency RNs were relied on by 25% of skilled nursing facilities.

Reasons RNs Left Employers

- The most frequently checked reasons why RNs left employers were: *personal reasons* and *employer incentives elsewhere.*
- Public health respondents checked *retirements* as often as the other reasons.

Increasing Demand for RNs

- Over 90% of hospital and home health employers and just over 60% of skilled nursing facility and public health employers expect the demand for RNs to increase in the next three years.
- Reasons listed most frequently by group were:
  - Hospitals: *Need to meet nurse-to-patient ratios*
  - Skilled nursing facilities: *Increasing patient acuity*
  - Public Health: *Other (bio-terrorism and retirements)*
  - Home health agencies: *Increases in market share*

Difficulty Recruiting RNs

- Respondents from over 80% of hospitals, public health agencies, and home health agencies, as well as nearly 70% of respondents from skilled nursing facilities indicated they were having difficulty recruiting RNs.

- Approximately 40% of respondents from all groups except public health indicated difficulty filling administrative and managerial positions.

Recruitment Methods

- The recruitment method listed by over 80% of all respondents was a*dvertisments in local newspapers*.
- Online services were used by over half of all employer groups except skilled nursing facilities.
- Over 40% of all respondents indicated that *employee referral (word-of-mouth, networking)* was the most productive recruitment method.

Recruitment Incentives

- Nearly two-thirds of hospitals, half of home health agencies, and a third of skilled nursing facilities offer *sign-on bonuses*.
- Public health respondents listed few incentives.

Primary Factor Negatively Impacting Recruitment

- Lack of ability to offer a *competitive salary and/or benefits* was the primary factor negatively impacting recruitment in 69% of public health agencies, 64% of skilled nursing facilities, 31% of home health agencies, and 29% of hospitals.

Support for Nursing Education as a Recruitment Method

- Almost all hospitals (90.4%) provide clinical experiences for nursing students as do 77% of public health agencies, 52% of home health agencies, and 45% of skilled nursing facilities.
- Financial support is given to nursing education programs by almost half of the hospitals and less than 10% of all other groups.

Additional Recruitment Concerns

- Respondents from all groups were concerned about: *insufficient numbers of RNs, need for additional nursing education programs,* and *inability to offer salary and benefits that are competitive with larger acute care facilities.*
- Agencies and facilities located in rural areas or high cost-of-living areas identified issues of *location* and *living costs* as factors impacting recruitment.

Retention Methods

- Flexibility in work scheduling was reported by 92% of home health, 85% of hospital, 80% of public health, and 74% of skilled nursing respondents.
- Financial assistance for baccalaureate or advanced degree education is offered by 80% of hospitals and almost half of public health and home health agencies.
- Growth opportunities, such as inservice education, are almost universal.

RN Involvement in the Organization

- Over half of the respondents from all groups indicated that RNs are involved in all levels of the organization (hospitals, 75%; home health, 73%; public health, 62%; and skilled nursing, 57%).
- Just over 60% of skilled nursing and public health respondents as well as approximately 75% of hospital and home health respondents indicated that RNs at all levels are involved in quality improvement processes.

RN Beliefs About Advocacy, Autonomy, Community Value, and Respect

- The percent of respondents from each group indicating that RNs in their organization believe *nurse leaders will advocate for their staff* was: hospitals, 93%; public health, 87%; home health, 86%; and skilled nursing, 69%.
- Belief that *RNs have autonomy in practice* was highest in home health (76%) and public health (74%) followed by hospitals (58%) and skilled nursing (44%).
- The perceptions that the *organization has value in the community* was highest in hospitals (88%) and home health agencies (84%) followed by public health agencies and skilled nursing facilities (both 66%).
- A belief that health care providers treat each other with respect was highest in skilled nursing facilities (67%) followed by home health agencies (61%), hospitals (48%), and public health agencies (44%).

Organizational Climate Changes

- Organizational changes to *promote feelings of being valued by RNs* were reported by respondents from: 73% of hospitals, 56% of home health agencies, 49% of public health agencies, and 28% of skilled nursing facilities.
- Respondents from 64% of hospitals, 38% of home health agencies, 31% of skilled nursing facilities, and 10% of public health agencies reported organizational changes to *decrease feelings of being overworked among RNs.*
- Organizational changes to *decrease the documentation workload for RNs* were reported by respondents from: 57% of hospitals, 56% of home health agencies, 39% of public health agencies, and 33% of skilled nursing facilities.
- Respondents from 64% of hospitals, 48% of home health agencies, 29% of skilled nursing facilities, and 26% of public health agencies reported organizational changes to *promote confidence in management among RNs.*
- Organizational changes to *promote respect among all health care professionals* were reported by respondents from: 60% of hospitals, 49% of public health agencies, 45% of home health agencies, and 32% of skilled nursing facilities.

Overtime

- Respondents from 72% of hospitals, 64% of skilled nursing facilities, 38% of home health agencies, and 19% of public health agencies reported that it was necessary to obtain overtime assistance from current staff on a routine basis to cover patient care requirements.

- No question directly addressed mandatory overtime. In response to a question about overtime policies in general, respondents from 24 hospitals (7%) wrote that overtime was never mandatory and 61 (34.5%) stated that overtime was strictly voluntary.

Compensation

- Compensation rate increases for *new graduates* during the past year were reported for 79% of hospitals, 54% of skilled nursing facilities, and 23% of public health agencies (home health agencies cannot employ new graduates).
- Compensation rate increases for *newly recruited experienced RNs* during the past year were reported for 83% of hospitals, 64% of skilled nursing facilities, 63% of home health agencies, and 27% of public health agencies.
- Compensation rate increases for *current RN employees* during the past year were reported for 85% of hospitals, 71% of home health agencies, 69% of skilled nursing facilities, and 31% of public health agencies.
- Four-fifths of hospital and home health, two-thirds of skilled nursing, but less than one-fifth of public health respondents indicated their salaries and benefits are competitive.

Significant Factors Negatively Impacting RN Retention

- Factors listed by respondents that negatively impact RN retention were summarized and placed into thematic categories. Highest rated factors among all respondent groups were:
  - Compensation competition (e.g., higher salaries/benefits/incentives elsewhere, competitiveness among providers)
  - Facility/agency characteristics (e.g., location, type)
  - Family/living issues (e.g., cost of living/housing)
  - RN Characteristics (e.g., aging workforce, commitment/competency)
  - Staffing/Workload (e.g., shortage of RNs, workload, paper compliance[skilled nursing and home health])

Comparison of Hospitals with High and Low Vacancy Rates

- Hospitals with low vacancy rates (below 5%) differed significantly from hospitals with high vacancy rates (18% and higher) in the following ways:
  - More high vacancy hospitals reported that RNs left for *employer incentives at another facility*
  - More high vacancy hospitals reported that RNs left for *job dissatisfaction*
  - High vacancy hospitals use more *travelers* and more *agency nurses* than low vacancy hospitals.
  - RNs *at all levels* are involved in quality improvement processes in more low vacancy hospitals compared to high vacancy hospitals.
  - More low vacancy hospitals reported that RNs have *autonomy* in their practice

Best Practices

- "Best practices" identified by respondents for hospitals were summarized and placed into the following thematic categories:
  - Benefits and incentives (e.g., bonuses for longevity, retention, preceptors)
  - Career trajectory for RNs (e.g., clinical ladders)
  - Interdisciplinary culture (e.g., interdisciplinary practice/workgroups)
  - Leadership (e.g., good staff/management relationships, formal leadership training, unit managers, town hall meetings, open-door policy, rounding)
  - Nursing education (e.g., good relationships with nursing schools)
  - Nursing practice (e.g., practice model changes, addition of support services)
  - Organizational culture (e.g., team/family spirit, nurturing environment)
  - Recognition (e.g., formal recognition program)
  - RN organizational involvement (e.g., self/shared governance, organization-wide or unit-based practice/quality committees, staff-driven initiatives)
  - Staffing/scheduling (e.g., self-scheduling)
  - Support for professional growth (e.g., new graduate/trainee programs, specialty training, scholarships/tuition reimbursement, preceptor preparation program, support for advanced certification, in-house nurse educators, onsite BSN/MSN programs)
- "Best practices" identified by respondents for skilled nursing facilities were summarized and placed into the following thematic categories:
  - Benefits and incentives (e.g., competitive salary/benefits, scholarships)
  - Interdisciplinary culture (e.g., interdepartmental support)
  - Leadership (e.g., good staff/management relationships, open communications)
  - Nursing practice (e.g., autonomy in practice)
  - Organizational culture (e.g., team/family spirit, respect/dignity)
  - Recognition (e.g., positive recognition)
  - RN organizational Involvement (e.g., organizational decision-making)
  - Staffing/scheduling (e.g., flexible scheduling)
  - Support for professional growth (e.g., continuing education)
- "Best practices" identified by respondents for public health agencies were summarized and placed into the following thematic categories:
  - Benefits and incentives (e.g., extra pay for certification)
  - Interdisciplinary culture (e.g., role of public health nurses [PHNs] in meeting strategic goals)
  - Leadership (e.g., support PHNs, consensus model)
  - Nursing practice (e.g., autonomy in practice)
  - Organizational culture (e.g., respect)
  - RN organizational Involvement (e.g., organizational input, decision-making, committee involvement)
  - Staffing/scheduling (e.g., include community work in schedule)
  - Support for professional growth (e.g., continuing education, recognition for growth)

- "Best practices" identified by respondents for home health agencies were summarized and placed into the following thematic categories:
  - Benefits and incentives (e.g., competitive salary, retention incentive)
  - Career trajectory (e.g., promotion track)
  - Interdisciplinary culture (e.g., collaborative clinical meetings, excellent communications)
  - Leadership (e.g., supportive administration, open-door policy, new leadership, treat RNs as customers)
  - Nursing practice (e.g., autonomy in practice)
  - Organizational culture (e.g., respect, team spirit, sense of ownership)
  - Recognition (e.g., formal recognition programs)
  - RN organizational Involvement (e.g., in business plan, workflow changes)
  - Staffing/scheduling (e.g., flexibility)
  - Support for professional growth (e.g., continuing education, extended orientation programs, preceptors)

Additional Comments

- Comments provided by respondents were categorized by employer group into themes: *Administration, Acute Care Competition, Bureaucratic Inhibition, Nursing Education, Nursing Practice, Organizational Culture, Recruitment Sources and Actions, Remuneration and Recognition, RN Shortage, Staff Organizational Involvement, Support for Professional Growth,* and *Recruitment and Retention Not An Issue.* Positive actions and areas of concern are included in the themes.
- No one theme predominated among hospital and public health respondents.
- Among skilled nursing respondents, positive actions relate primarily to the theme of *Organizational Culture* and the action of *sponsoring foreign nurses* under the theme of *Recruitment Sources and Actions.* Areas of concern are reflected predominately in the areas of *Administration, Acute Care Competition, Bureaucratic Inhibition,* and *Remuneration and Recognition*.
- Among home health respondents, positive actions in the theme of *Organizational Culture* and areas of concern in the themes of *Bureaucratic Inhibition* and *Nursing Practice* predominate.

Recommendations and Resources

- The primary recommendations across all employer groups related to increasing the number of nursing students and graduates. Recommendations to increase enrollments in current programs, add additional programs, provide support for faculty, and recruit students into programs were universally evident.
- Hospital respondents most often included recommendations related to the themes of *Ratios and Regulations/Legal Issues.*
- Home health respondents most often also included recommendations related to the theme of *Reimbursement/Regulations.*
- All of the employer groups listed state funding as a source of funding for non-organizational initiatives.

Conclusions

- Many of the "best practices" listed are among those shown to be related to recruitment and retention in previous studies and reflect *Magnet* criteria.
- Smaller rural hospitals, skilled nursing facilities public health agencies and some home health agencies are unable to compete with the salaries, benefits and incentives offered by larger hospitals.
- Many non-hospital respondents list salary as a major deterrent to recruitment and retention; they also list "best practices" that positively influence retention and recruitment even though salaries are not competitive.
- The nursing shortage is identified as a major deterrent to recruitment of RNs.
- All employer groups identified expansion of current nursing education programs as well as an increase in the number of nursing education programs as critical to assuring recruitment and retention of an appropriate nursing workforce.

RN Employer Survey

Final Report

Recruitment and retention of registered nurses (RNs) is a major health care concern. The acute and growing shortage of RNs in California, the United States, and worldwide has highlighted the importance of identifying and resolving nursing workforce issues in order to recruit and retain nurses in the workplace.

Purposes of the Survey

The California Board of Registered Nursing (BRN) surveyed employers of nurses in the State related to their RN recruitment and retention experiences. Study methods are described in Appendix A. The RN Employer Survey data collection instrument is located in Appendix B. The key purposes of the RN Employer Survey were: "to identify difficulties in recruiting and retaining RNs, best practices that have resulted in reduction of nurse workforce issues, recommendations for changes needed to resolve nursing workforce issues and current conditions and issues."

General Information Responses

Respondents and Response Rate. A sample of 1194 chief nursing officers or directors of nursing from 395 hospitals, 438 skilled nursing facilities, 63 public health agencies, and 298 home care/home health/hospice (home health) agencies were asked to respond to the survey between April 19 and June 15, 2004. Anonymity of responses was assured. A total of 490 chief nursing officers, directors of nursing, or their designate returned responses in time for their responses to be included in the analysis. The overall response rate was 41.0%. Responses were received from 177 hospitals (44.8% response rate), 155 skilled nursing facilities, (35.4% response rate), 39 public health agencies (61.9% response rate), and 119 home health agencies (39.9% response rate). Responses from 19 continuing care/life care facilities were included with the skilled nursing responses.

Percent of RN Positions Vacant. Respondents were asked to indicate what percent of current budgeted RN positions that they would fill if they could were vacant. The responses are meaningful only for hospitals since other types of facilities or agencies may have few RNs. A total of 154 hospital respondents indicated that anywhere from 0% to 35% of positions were vacant. The mean hospital RN budgeted position vacancy rate was 11.0% (median=10%; SD=6.9%). A total of 30 (19.5%) of the 154 respondents listed vacancy rates below five percent; 33 (21.4%) of the respondents recorded vacancy rates above 18%. For purposes of comparative analysis, these groups were designated as high vacancy and low vacancy hospitals.

Reasons RNs Left. Respondents were asked to indicate the top three reasons RNs left their facility or agency during the previous year. The number and percent of respondents from each type of facility or agency indicating a specific or other reason are shown in Table 1. For all groups, the two highest number of reasons indicated by respondents were *personal reasons* and *employer incentives at another facility.* Among public health respondents, *retirements* was selected with the same frequency as *employer incentives at another facility.*

Table 1. Number and percent of hospital, skilled nursing facility, public health agency, and home health agency respondents indicating reasons why RNs left the facility last year.

Reasons Why RNs Left	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Retirement	51	28.8	10	6.5	18	46.2	13	10.9
Termination for poor performance	64	36.2	33	21.3	5	12.8	28	23.5
Employer incentives at another facility	109	61.6	71	45.8	18	46.2	51	42.9
Personal reasons	147	83.1	58	37.4	25	64.1	69	58.0
Job-related stress, illness or injury	8	4.5	21	13.5	1	2.6	13	10.9
Job dissatisfaction	26	14.7	22	14.2	9	23.1	29	24.4
Layoffs	0	0	1	0.1	1	2.6	4	3.4
Other	46	26.0	32	20.6	4	10.3	26	21.8

Respondents from significantly more high vacancy hospitals than low vacancy hospitals reported that RNs left for *employer incentives at another facility* ($?^2$=4.58, *df*=1, *p*=.032) and for *job dissatisfaction* ($?^2$=5.00, *df*=1, *p*=.025). Differences between the groups were not significant for the remaining reasons.

The *other* reasons why RNs left the facility listed by hospital respondents included: *not meeting per diem or hours requirements, nursing license issues, wages, cost of living, internal transfer, management/administration issues, scheduling/shift difficulties, working conditions,* and *gaining experience for use elsewhere.* Skilled nursing respondents listed the following *other* reasons: *changing to acute care, home care, or hospice for better wages; inability to meet on-call or per diem requirements, interpersonal conflict, high patient-to-nurse ratio, too much documentation, job responsibilities,* and *availability of 12-hour shifts in acute care.* Public health respondents listed: *low salary; career change*; and *schedule difficulties.* Home health respondents included the following *other* reasons: *higher wages and better benefits elsewhere, company restructuring, disliked commuting, too much documentation, breach of contract by foreign nurse recruits,* and *job unsuitability.* Each reason was listed by fewer than five percent of respondents.

Travelers. RNs from other states who are willing to travel to California for a specified period of time are employed by 74.3% of hospitals. On average, travelers are used by 7.9% of hospital RN full-time equivalent (FTE) positions (range=<1% to 45%; median=6%; SD=7.6%). Significantly more high vacancy than low vacancy hospitals employed travelers ($?^2$=6.45, *df*=1, *p*=.011). The percent of RN FTEs covered by travelers was also significantly higher in high vacancy hospitals (*t*=-6.12, *p*<.0001). Travelers were employed by 3.9% of skilled nursing facilities and 5.9% of home health agencies. None of the public health agencies employed travelers.

Agency RNs. RNs hired through in-state agencies to fill shift and FTE vacancies were used by 78.9% of hospitals. Agency RNs covered 5.5% of hospital RN FTEs on average (range=<1% to 45%; median=3%; SD=7.3%). Differences were not significant between high and low vacancy hospitals in the number of hospitals using agency RNs but the percent of FTEs covered by agency RNs was significantly higher in high vacancy hospitals (*t*=-2.692, *p*=.01).

Agency RNs were used by 25.2% of skilled nursing facilities, 5.3% of public health agencies, and 5.9% of home health agencies. Among the 41 skilled nursing facilities using agency nurses, 6.9% of RN FTEs were covered by agency RNs on average (range=<1% to 50%; median=2%; SD=11.4%).

Increased Demand for Services. Respondents for 94.3% of hospitals, 92.4% of home health agencies, 63.2% of skilled nursing facilities, and 61.5% of public health agencies expect the demand for RN services to increase over the next three years in their facilities or agencies. Employers were asked if the demand was due to *market share increases*, the *need to meet nurse-to-patient ratios*, *increased patient acuity*, or *other* reasons. Table 2 shows the number and percent of respondents indicating each of the reasons for increasing RN demand among employers indicating they expect increasing demand.

Table 2. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating each of the reasons why demand for RNs will increase.

Reason for Increased RN Demand	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Increased market share	88	49.7	19	12.3	1	2.6	70	58.8
Need to meet nurse-to-patient ratios	135	76.3	33	21.3	2	5.1	20	16.8
Increased patient acuity	89	50.3	74	47.7	2	5.1	41	34.5
Other	48	27.1	12	12.5	20	51.3	25	21.0

Three-fourths of hospital employers indicated they expect demand for RNs to increase based on the *need to meet nurse-to-patient ratios*. *Market share increases* and *increased patient acuity* were each identified as reasons for increased RN demand by half of these employers. *Other* reasons listed by hospital employers were:

expansion of services or facilities (N=17, 9.6%); and *retirements* (N=15, 8.5%). Fewer than five percent of hospital respondents listed: *population growth; increased workload/technology; implementation of 12-hour shifts; regulatory standards in addition to nurse-to-patient ratios; general attrition*; and *closure of a nearby facility.*

Among skilled nursing employers, almost half indicated that *increased patient acuity* will contribute to increasing demand for RNs in their facilities. *Retirement of RNs, licensing/regulatory requirements, opening subacute units, offering more services, increasing census* and *a change in nursing leadership* were the *other* reasons noted.

Half of public health respondents indicated that increasing demand was related to *other* reasons. These included: *increasing public health and safety issues including bio-terrorism preparedness* (N=8, 20.6%); *retirement of existing staff* (N=7; 17.9%); *population growth* (N=4; 10.3%); and *increased work due to grants received* (N=4; 10.3%). *Jail coverage* and *increased use of public health nurses (PHNs) in the community* were each listed by one respondent.

Increased market share and *increasing patient acuity* were the primary reasons for increased demand in home health. *Aging population* and *increasing census* were each listed as an *other* reason by 7.3% (N=8) of respondents. Additional reasons listed by fewer than five percent of these respondents included: *increased hospice referrals, earlier hospital discharges, retirement, and turnover.*

Recruitment

Recruitment Difficulties. Most of the surveyed employers are having difficulty recruiting RNs. Respondents from 88.9% of hospitals, 82.2% of home health agencies, 81.6% of public health agencies and 68.0% of skilled nursing facilities indicated that they were experiencing difficulty.

Of the 152 hospitals experiencing recruitment difficulty, 54 (35.5%) indicated difficulty in all areas, while 98 (64.5%) identified difficulties only in specific specialty areas. Specialty areas identified by more than 20 respondents were: intensive care (N=66), emergency department (N=52), operating room (N=37), labor and delivery (N=32), and general medical units (N=29). Data for all hospital specialties are shown in Table C-1, Appendix C (p. 43).

Specific Shifts or Hours. Respondents were asked to indicate if recruitment difficulties are related to specific shifts or hours. Difficulties were acknowledged by 58% of hospital respondents, 32.3% of skilled nursing respondents, and 5.1% of both public health and home health respondents. Differences between high and low vacancy hospitals were not significant.

Difficulty Filling RN Administrative/Managerial Positions. Difficulty filling RN administrative/managerial positions was affirmed by respondents for 43.6% of public

health agencies, 43.4% of hospitals, 40.6% of skilled nursing facilities, and 13.4% of home health agencies. Differences between high and low vacancy hospitals were not significant.

Employment of a Nurse Recruiter. Nurse recruiters are employed by 55.2% of hospitals. Of these, 85% are full-time and 15% are part-time. Differences between high and low vacancy hospitals were not significant.

Among home health agencies, 26.5% employ a nurse recruiter with 90% employed full-time. Notations indicate that many of these home health agencies are part of larger corporations who employ the recruiter. Only 7.5% of skilled nursing facilities and 5.3% of public health agencies employ nurse recruiters. Notations again indicate that these recruiters are likely to be corporate or county-level recruiters or human resources personnel.

Recruitment Activities. Recruitment methods used by employers are presented in Table 3. Over 80% of all groups place *advertisements in local newspapers*. In addition, *advertisements in nursing newspapers*, *in-state job fairs*, and *online services* each were identified as recruitment methods by over 75% of hospital employers. *Online services* also were used by over half of the public health and home health agencies and by about a quarter of the skilled nursing facilities.

Table 3. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating recruitment methods used.

Recruitment Methods	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Advertisements in local newspapers	147	83.1	135	87.1	35	89.7	100	84.0
Advertisements in statewide newspapers	43	24.3	11	7.1	13	33.3	17	14.3
Advertisements in national newspapers	34	19.2	2	1.3	3	7.7	3	2.5
Advertisements in nursing newspapers	126	71.2	13	8.4	16	41.0	53	44.5
Advertisements in nursing magazines	70	39.5	5	3.2	5	12.8	18	15.1
Direct mailings to RNs	86	48.6	12	7.7	7	17.9	42	35.3
Job fairs, in-state	140	79.1	26	16.8	15	38.5	63	52.9
Job fairs, out-of-state	51	28.8	1	0.6	1	2.6	7	5.9
Online services	133	75.1	41	26.5	23	59.0	68	57.1
Recruitment of nurses from other countries	76	42.9	32	20.6	5	12.8	9	7.6
Other	36	20.3	39	25.2	10	25.6	25	21.0

More high vacancy than low vacancy hospitals place ads in statewide ($?^2$=3.96, *df*=1, *p*=.047) and national ($?^2$=3.96, *df*=1, *p*=.047) newspapers. High vacancy hospitals are also significantly more likely to use online services ($?^2$=4.09, *df*=1, *p*=.043). Differences in the other recruitment methods were not significant.

Employee referral (*word-of-mouth, networking*) was the most common *other* recruitment method listed by skilled nursing facilities (N=36; 23.2%) and home health agencies (N=21; 17.6%). *Nursing school program outreach* was the most common *other* recruitment method in hospitals (N=12; 6.8%). Public health respondents listed *county flyers and mailings* as the most common *other* method (N=4; 10.3%).

Additional *other* methods were listed by fewer than five percent of respondents from any one group. Hospital respondents listed *employee referral, open house, website, search firms, student worker program, billboards,* and *sponsorship of international recruits.* Skilled nursing respondents listed *professional recruiters, postings at local schools, Penny Saver,* and *signage in front of the facility.* Public health respondents listed *nursing school outreach*. Home health respondents listed *open house, radio and TV advertisements,* and *notices at the local hospital*.

Recruitment Incentives. As shown in Table 4, nearly two-thirds of hospitals, half of home health agencies, and a third of skilled nursing facilities offer *sign-on bonuses*. *Housing subsidies* are offered by few employers. There were no differences between high and low vacancy hospitals in the proportions offering sign-on bonuses.

Table 4. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating recruitment incentives used.

Recruitment Incentives	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Housing subsidies	16	9.0	9	5.8	0	0	1	0.8
Sign-on bonuses	109	61.6	45	29.0	0	0	54	45.4
Other	61	34.5	23	14.8	6	15.4	30	25.2

Other recruitment incentives listed by hospital respondents included *relocation assistance* (N=29; 16.4%), e*mployee referral bonuses* (N=27;15.3%), and *tuition/loan reimbursement* (N=9; 5.1%). Fewer than five percent of this group listed *retention bonus, bilingual bonus, COBRA assistance, specialty training,* and *flexible shifts.*

Fewer than five percent of skilled nursing respondents listed the following *other* recruitment incentives: *higher wages, preferred schedule accommodation, travel allowance, COBRA reimbursement, license renewal reimbursement, scholarships, shift differential, recognition and rewards, sponsorship program, meals on some shifts,* and *free gym membership*. Work environment features were also listed and included *friendly staff* and *better work environment*.

Public health respondents listed few incentives. Those listed by one or two respondents included *county/state benefits, relocation assistance,* and *internship opportunities for BSN students.*

Ten home health respondents (8.4%) listed *employee referral bonus* as an *other* recruitment incentive. Fewer than five percent of these respondents listed *relocation assistance, employee ownership, 10-hour shifts, flexible scheduling, good/competitive benefits, wages higher than community standard,* and *quarterly/yearly bonuses.*

Differential Pay. The number and percent of employers offering differential pay for specific shifts, education background, certification, or other reasons are shown in Table 5. About twice as many hospitals as skilled nursing facilities offer differentials for evening, night, and weekend shifts. Differential pay for education level and certification is also offered at proportionately more hospitals than other types of agencies or facilities. It should be noted that most public health respondents did not indicate a differential for the baccalaureate degree which is required for PHNs. Differences between high and low vacancy hospitals were not significant for any of the differential pay categories.

Table 5. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating differential pay for shifts, education, certification or other factors.

Differential Pay Category	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Evening shift	139	78.5	63	40.6	3	7.7	30	25.2
Night shift	173	97.7	85	54.8	2	5.1	27	22.7
Weekend shift	74	41.8	25	16.1	2	5.1	39	32.8
Baccalaureate degree	34	19.2	2	1.3	3	7.7	9	7.6
Masters degree	22	12.4	1	0.6	2	5.1	7	5.9
Certification by national organizations	47	26.6	0	0	1	2.6	16	13.4
Other	26	14.7	6	3.9	9	23.1	15	12.6

Other differential pay categories listed by hospital respondents were: *preceptors, charge nurse/team leaders, mobile intensive care nurses, emergency room, in-house registry/float pool, bilingual abilities, locked units, weekender program/extra weekends,* and *higher levels of the clinical ladder. Extra shift bonus* and *certification (one time) bonus* were also listed.

Respondents for skilled nursing facilities listed *other* pay differentials for *no 12 hour rest* and *acute psych care.* Public health respondents listed *jail coverage* and *bilingual skills*. *Comp time* was also listed by respondents from the public health agencies. Home health respondents listed *case management, after hours, per case basis, PHN*

(first year only) and *on-call bonus*. None of the *other* differential categories were listed by more than five percent of respondents from any one group.

Most Productive Recruitment Methods. Respondents were asked to list recruitment methods that were the most productive. *Employee referral (word-of-mouth, networking)* was the most productive for respondents from 44.1% of hospitals, 51.6% of skilled nursing facilities, 48.7% of public health agencies, and 42.9% of home health agencies. *Newspaper ads* were the next most frequently cited productive method for 30.8% of public health agencies, 26.5% of skilled nursing facilities, and 19.3% of home health agencies. The second most frequently cited method in the hospital group was *involvement with local schools of nursing* which was listed by 11.3% of respondents. Table C-2, Appendix C (p. 44) contains a listing of specific productive recruitment methods by employer group.

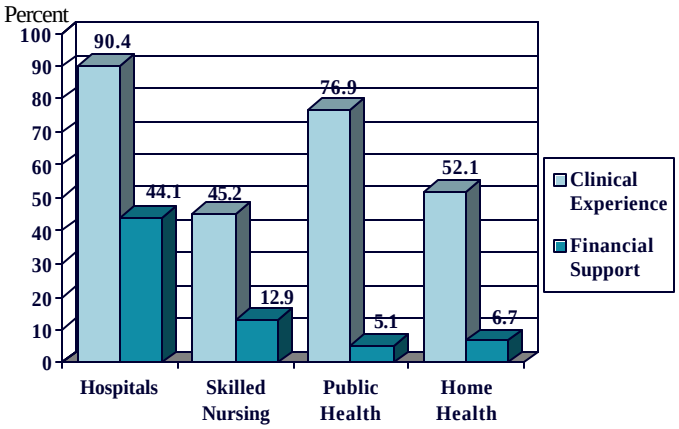
A few respondents included comments in response to this question related to difficulty recruiting. Comments included: *nothing works, recruitment is a matter of chance if someone moves to the area,* and *sign-on bonuses are no longer effective.* Two respondents indicated that *retention of current staff* was their best recruitment method; one respondent added that *tuition benefits* help with retention.

Significant Factors Negatively Affecting Recruitment. Respondents were asked to list the most significant factors that negatively impact the ability to recruit experienced RNs in their facility or agency. A listing of factors negatively affecting recruitment of experienced RNs is presented by employer group in Table C-3, Appendix C (p. 45). Ability to offer competitive s*alary and/or benefits* was the primary negative recruitment factor for 69.2% of public health, 63.9% of skilled nursing, 31.1% of home health, and 29.4% of hospital employers. More than 20% of hospital and public health respondents listed *location* as a negative factor. *Cost of living/housing* was listed by more than 10% of both groups and *the RN shortage* was listed by more than 10% of hospital respondents. *Competition* was listed by between 5% and 10% of hospitals, skilled nursing facilities and home health agencies; it was often addressed in the context of large acute care facilities with more resources.

Support for Nursing Education. Respondents were asked if they provided clinical experience opportunities for nursing students and financial support for nursing programs. Figure 1 shows the percent of each group responding affirmatively. Almost all of the hospitals indicated that they offer clinical experiences to nursing students. Financial support was given to nursing programs by almost half of the hospital employers. There were no differences in either offering clinical experiences or financial support among high and low vacancy hospitals. Although asked to respond only for RN pre-licensure students, skilled nursing respondents may have answered affirmatively if clinical experiences were provided for vocational nursing and/or nursing assistant programs.

Employers were also asked if they formally partnered with nursing programs in ways other than providing clinical experiences. Fewer than five percent of respondents in

Figure 1. Clinical experience and financial support by employer group



any employer group provided the following responses. Hospital respondents indicated they provide: *clinical instructors, preceptorships, externships, mentorship programs, work-study program, stipends, student loans, involvement in school advisory boards,* and *classroom/skills lab space at the hospital*. The Director of Nursing Services in one skilled nursing facility participates as a *guest lecturer* for nursing assistant students. Another facility sponsors a vocational nursing student *geriatric care award.* Public health nurses participate as *guest lecturers* for baccalaureate nursing programs, *participate in school meetings related to strengthening partnerships and mentorships, offer externships* and *provide scholarships.* Home health agencies *offer preceptorships for RN to BSN students*, and are working on developing *externships* in some agencies. One respondent from home health indicated their agency would be willing to train new graduates if regulations permitted.

Support for Student Nurses or New Nurse Graduates. Respondents were asked to indicate types of support offered student nurses or new nurse graduates as a means of recruitment. The number and percent of respondents from each employer group indicating each type of support appears in Table 6. Home health respondents were omitted from these analyses since they are unable to hire new graduates. The primary support offered among the remaining three groups was *extended new graduate orientation*. Hospital employers were more likely to offer each of the types of support. There were no differences in any of the support variables between high and low vacancy hospitals.

Other support offered by hospitals included: *scholarships, repayment of school loans, new grad program, new grad support groups, preceptor training,* and *student nurse trainee program.* Skilled nursing facility respondents identified *free continuing education units* and *support for staff working toward becoming a licensed vocational nurse (LVN) or RN*. One respondent indicated that the facility finances foreign-educated RNs who work as certified nursing assistants while completing requirements for their LVN license. Public health respondents listed *post-degree education* as an

Table 6. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating types of support for student nurses or new nurse graduates.

Type of Support	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)	
	N	%	N	%	N	%
Financial support for entry-level students in exchange for a service commitment	59	33.3	20	12.9	2	5.1
Paid externships during the nursing education program	55	31.1	5	3.2	5	12.8
New graduate internships	78	44.1	9	5.8	1	2.6
Extended orientation for new graduates	135	76.3	74	47.7	15	38.5
Mentorship program	79	44.6	26	16.8	7	17.9
Other	34	19.2	5	3.2	3	7.7

other type of support. No support activity was listed by more than five percent of respondents from a group.

Additional Comments About Recruitment. Respondents had the opportunity to include any additional comments they wanted to make about the recruitment of new or experienced RNs. Additional comments about recruitment are summarized by employer group in Table C-4, Appendix C (p. 46). Comments were categorized into the following themes: *Applicants; Compensation and Cost-of-Living; Nursing Education; Recruitment Methods;* and *Work Environment*.

Respondents from all groups were concerned about: *insufficient numbers of RNs, need for additional nursing education programs,* and *inability to offer salary and benefits that are competitive with larger acute care facilities.* Agencies and facilities located in rural areas or high cost-of-living areas identified issues of *location* and *living costs* as factors impacting recruitment.

Retention

Flexibility in Work Scheduling. Respondents were asked whether their facility or agency allows flexibility in work scheduling. The percentage of each employer group indicating flexibility in scheduling was: hospitals, 84.7%; skilled nursing facilities, 74.2%; public health agencies, 79.5%; and home care agencies, 92.4%.

Employers were asked to indicate what options were available if scheduling flexibility was allowed. Options in hospitals and skilled nursing facilities were highly varied with considerable flexibility in hours worked and shifts. In hospitals, the two most frequently listed options were *shift length* of 4, 8, 10 or 12 hours (N=51; 28.8%) and *self-scheduling* (N=32; 18.1%). Additional options listed included: *flexibility around school or family responsibilities; consider any reasonable request; weekends only; job sharing; split, staggered, fixed or mixed shifts; variety of hours and days*

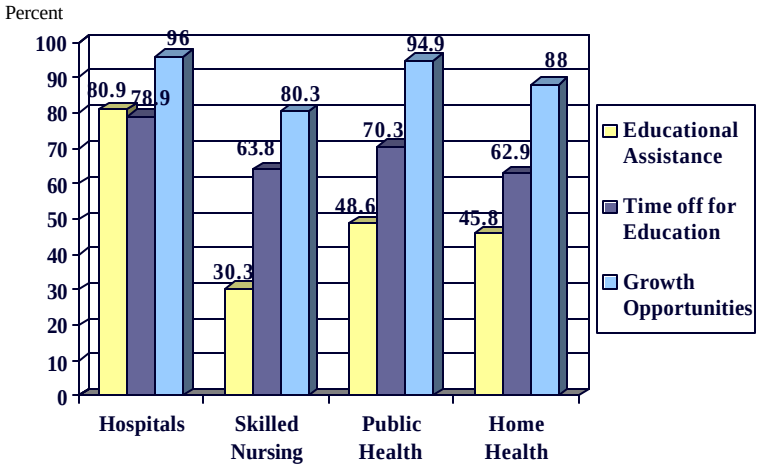
options; and *per diem options.* Skilled nursing facilities respondents most often indicated that their facility will *adjust hours, days, and shifts as needed* (N=47; 30.3%). *Requested days off, part-time, job sharing, RN self-scheduling,* and *exchanging days or shifts* were also listed.

Public health respondents indicated the *option of working four 10-hour days* most frequently (N=16; 41%). *Varying start times, nine-hour days, flexible hours, job-sharing,* and *part-time* options were also listed. Home care respondents listed *self-scheduling* most often (N=37; 31.1%). Other home care options listed include: *part-time, job sharing, 10-hour days, per diem, on-call.* One respondent indicated that the agency works around the full-time RN schedules from other facilities. Several respondents indicated that home care is very flexible.

Education and Professional Growth Support. Respondents were asked if their facility or agency: 1) offers financial assistance for RNs who want to obtain a baccalaureate or advanced degree; 2) if time off is provided for RNs to obtain further education; and 3) if growth opportunities, such as inservice education, is offered. Figure 2 shows the percent of each group that answered these questions affirmatively.

Financial assistance for baccalaureate or advanced degree education was offered by 80% of hospitals and almost half of public health and home health agencies. Respondents from skilled nursing facilities indicated that support includes CNA to LVN and LVN to RN education support. Time off for further education was supported by the majority of facilities and agencies. Growth opportunities, such as inservice education, were almost universal. There were no differences between high and low vacancy hospitals in any of the areas.

Figure 2. Educational and professional growth support by employer group



Examples of growth opportunities were requested. A listing of growth opportunities other than inservice education or on-site continuing education appears in Table C-5, Appendix C (pg. 50).

Growth opportunities were categorized into the following themes: *Education Support, In-House Targeted Programs,* and *Recognition for Growth.* In addition to inservice and on-site continuing education, hospital employers most often listed: *satellite, online and/or home study continuing education programs; paid or partially paid continuing education/conference days*; and *scholarship/tuition assistance* as educationally supported growth opportunities. Skilled nursing facilities listed *off-site continuing education courses/seminar/workshops* most frequently. Two skilled nursing respondents indicated they did not receive growth support and were expected to complete required minimum data set (MDS) continuing education at their own expense. Public health agencies listed *state-sponsored training programs* and home health agencies listed *reimbursement for specialty courses/certifications* most often. *Certification programs* were also listed as growth opportunities by 20 hospital employers who provide the programs in-house.

RN Involvement in the Organization. Respondents were asked to check the type of involvement RNs had in their organization. They were free to select multiple responses which are shown in Table 7. Over half of the respondents from all groups indicated that RNs are involved in all levels of the organization. Differences between the high vacancy and low vacancy hospitals were not significant for any of the types of organizational involvement.

Other responses were listed by one respondent each. For hospitals, responses included: *Chief Nursing Officer meetings with staff, a Nurse Champion group, professional practice forum, RNs in top administrative roles,* and *working toward Magnet status*. *Other* skilled nursing facility responses included: *involvement in quality improvement, staff development,* and *corporate services.* Public health agencies listed: *RNs in top administrative roles, union-management committee, PHNs as integral to the organization,* and *clinical governance.* Home health respondents listed: *RN-run nursing forum*, *case management,* and *team/group conferences.*

Table 7. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating types of RN involvement in their organization.

Type of Organizational Involvement	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Unit-based decision-making	130	73.4	62	40.0	17	43.6	35	29.4
Committee representation	133	75.1	59	38.1	19	48.7	65	54.6
All levels of the organization	132	74.6	88	56.8	24	61.5	87	73.1
Other	16	9.0	7	4.5	7	17.9	10	8.4

Models of Care. Information on models of care was pertinent primarily to hospitals. Hospital respondents often indicated that care models were unit-dependent and that multiple models were used in their facilities. Models of care most often cited by these respondents were: *team* or *modified team nursing* (N=95; 53.7%); *primary* or

modified primary nursing (N=65; 36.7%); and *total care* (N=18; 10.2%). Three respondents listed *interdisciplinary holistic or professional practice* models.

RN Involvement in Quality Improvement. Respondents were asked to select the type of RN involvement in quality improvement processes at their facility or agency from among four choices. The number and percent of respondents indicating each type of involvement is shown by employer group in Table 8. Across all employer groups, 60% or more of the respondents indicate that RNs at all levels are involved in quality improvement processes.

Table 8. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating each type of involvement in quality improvement processes.

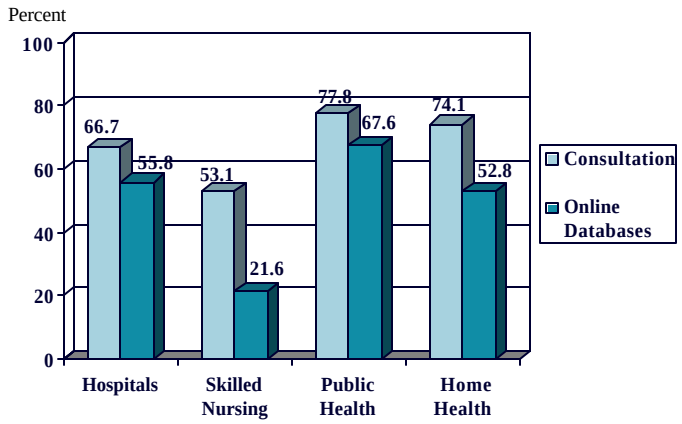
Quality Improvement (QI) Involvement	Hospitals (N=175)		Skilled Nursing (N=150)		Public Health (N=36)		Home Health (N=116)	
	N	%	N	%	N	%	N	%
RNs at all levels are involved	136	77.7	94	62.7	22	61.1	86	74.1
RNs in leadership positions are involved	31	17.7	43	28.7	9	25.0	17	14.7
QI processes are the responsibility of specific RNs	7	4.0	13	8.7	3	8.3	13	11.2
RNs are not involved	1	0.6	0	0	2	5.6	0	0

There were significant differences between high vacancy and low vacancy hospitals on the level of quality improvement involvement ($?^2$=10.68, *df*=2, *p*=.005). In 90% of the low vacancy hospitals, RNs at all levels were involved in quality improvement processes compared to 54% for high vacancy hospitals.

Availability of Consultation and Online Resources. Respondents were asked if consultation from advanced practice nurses and/or peer networks is available to staff RNs. They were also asked if RNs have access to online nursing databases and journals from their patient care units. Figure 3 shows the percent of each respondent employer group answering questions affirmatively. Over half of all groups have access to advanced practice RNs and/or peers for consultation. About half of all groups except skilled nursing facilities have unit access to online nursing databases and/or journals. There were no differences between high and low vacancy hospitals for availability of consultation or online resources.

Kinds of Consultation Available. Respondents listed a wide range of sources of consultation available to them. A total of 58 hospital respondents (32.8%) indicated availability of consultation from *advanced practice nurses* (clinical nurse specialists and nurse practitioners). Respondents from both hospital and skilled nursing groups listed: *consultants from other nursing specialties (e.g., mental health), nurses with special certifications (e.g., wound care), unit directors and nursing administrators,* and *consultants from other disciplines, (e.g., social service). Mentors, preceptors,*

Figure 3. Availability of consultation and online resources



performance/practice teams, educators (some unit-based), peer networks, case managers and *telemedicine conferencing* were also listed by hospital respondents.

Several skilled nursing respondents indicated that they have regularly scheduled nurse consultation visits contracted by the facility or regional nurse consultant visits contracted at the corporate level. Skilled nursing respondents also listed the availability of consultation from a *geriatric nurse practitioner* or *Kaiser nurse practitioner* for patients with Kaiser insurance.

Public health respondents noted the presence of *advanced practice nurses* on their staffs (N=9; 23.1%). They also listed: *access to nurse consultants through the State Department of Health, health officers, program leads, supervisors, state and regional program staff, on-duty consultants for communicable diseases,* and *mentors for less experienced staff.*

Consultation from nurses *certified in wound/ostomy/continence care* was listed most frequently by home care respondents (N=26; 16.8%). Consultation from *advanced practice nurses* was listed as available to 20 agencies (12.9%). Home care respondents also listed: *nurses with special certifications other than wound care (e.g., diabetic educator), interdisciplinary team members (e.g., pharmacist), supervisors, medical director,* and *peers.*

RN Beliefs About the Organization. A series of four statements about health care organizations were presented. Respondents were asked to check all of the responses with which they believed RNs at their facility or agency would agree. The four statements were: 1) nurse leaders in the organization will advocate for their staff; 2) RNs have autonomy in their practice; 3) The organization is valued in the community; and 4) all health care providers treat each other with respect. The number and percent of respondents answering the statement affirmatively is shown by employer group in Table 9.

The number of respondents indicating that RNs in their organization believe *nurse leaders will advocate for their staff* is highest in hospitals, public health agencies and home health agencies. *RN autonomy* responses are highest in public health and home health. *Community value* responses are highest among hospital and home health respondents. Responses indicating *respect among health care providers* are highest in the skilled nursing facility and home health agency groups.

Table 9. Number and percent of hospital, skilled nursing, public health, and home health respondents agreeing with statements related to RN beliefs about the organization.

Beliefs About Organization	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Nurse leaders advocate for staff	165	93.2	107	69.0	34	87.2	102	85.7
RNs have autonomy in practice	102	57.6	68	43.9	29	74.4	90	75.6
Organization is valued in the community	155	87.6	102	65.8	26	66.7	100	84.0
Health care providers treat each other with respect	84	47.5	104	67.1	17	43.6	73	61.3

Significantly more respondents for low vacancy hospitals than high vacancy hospitals indicated that *RNs have autonomy in their practice* ($?^2$=5.04, *df*=1, *p*=.025). Differences were not significant for the other beliefs.

Organizational Climate Changes. A series of questions was designed to ascertain if organizational climate changes had been made to address issues of concern to RNs. Questions related to: 1) promoting feelings of being valued; 2) decreasing concerns about being overworked; 3) decreasing the documentation workload; 4) promoting confidence in management; and 5) promoting respect among all health care professionals. Table 10 shows the number and percent of respondents by employer group indicating that the agency or facility for which they are answering has addressed organizational climate changes in specific areas.

A larger proportion of affirmative responses are present in the hospital group than in any other group for each of the organizational climate changes. Home health agencies, overall, report a higher proportion of positive responses than public health and skilled nursing. There were no differences among high and low vacancy rate hospitals in any of the organizational change areas.

Promoting Feelings of Being Valued Among RNs. Respondents who answered affirmatively that organizational climate changes were being made to *promote feelings of being valued among RNs* were asked to list the kinds of changes that have been made. Responses are summarized by employer group in Table C-6, Appendix C (pg. 52). Responses were categorized into the following themes: *Addressing RN Concerns; Administrative Actions; Interdisciplinary Relationships; Patient Care*

Table 10. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating that organizational climate changes have been made in specific areas.

Organizational Climate Changes	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Promote feelings of being valued	130	73.4	44	28.4	19	48.7	67	56.3
Decrease concerns about being overworked	113	63.8	49	31.6	4	10.3	45	37.8
Decrease documentation workload	102	57.6	51	32.9	15	38.5	67	56.3
Promote confidence in management	113	63.8	45	29.0	10	25.6	57	47.9
Promote respect among all health care professionals	106	59.9	50	32.3	19	48.7	53	44.5

Focus; Recognition Programs/Strategies; RN Organizational Involvement; Salary and Benefits; Staffing; and Support For Professional Growth.

The methods listed most often for obtaining information related to *Addressing RN Concerns* were *staff satisfaction/opinion surveys*, primarily in hospitals, or *staff meetings* in all groups. Multiple changes were listed by one or more respondents, primarily in the hospital group, related to *Administrative Actions* although all groups listed *open-door policy/open communications. Interdisciplinary Relationships* and *Patient Care Focus* changes were listed primarily by hospital respondents. Across all groups, the *Recognition Programs/Strategies* theme contained multiple individual recognition and group appreciation activities. *RN Organizational Involvement* is characterized by *more involvement in policy and decision-making* activities in all groups except public health agencies, although the activity may be the norm for that group. *Increases in salary* are the predominant response under *Salary And Benefits* in all groups except public health. In the *Staffing* theme, *staffing changes*, including increases in nursing and support staff, are listed by all group respondents except public health. Hospital respondents listed *clinical ladder and mentor/preceptor programs* most frequently in relation to the theme of *Support for Professional Growth*. Other employer groups listed *increases in inservice education.*

Decreasing RN Concerns About Being Overworked. Respondents who answered affirmatively that organizational climate changes were being made to *decrease RN concerns about being overworked* were asked to list the kinds of changes that have been made. Listed changes are summarized by employer group in Table C-7, Appendix C (pg. 58). Responses were categorized into the following themes: *Staffing; Streamlining Work Processes; Addressing RN Concerns; Administrative Actions; Patient Acuity; Focused Education/Training; Recognition and Appreciation;* and *Role Benefits.*

Most of the comments in all groups were related to the theme of *Staffing*. *Nurse-to-patient ratios* were identified most often by hospital employers as a change resulting in a decrease in RN concerns about overwork. In addition, *increases in the number of RNs and ancillary staff* were listed frequently by respondents in all groups except public health. Hospital, skilled nursing and home health respondents listed *decreases in documentation and paperwork* most often as a reason for a decrease in RN concerns about being overworked within the theme of *Streamlining Work Processes.*

Decreasing the Documentation Workload for RNs. Respondents who indicated that organizational climate changes were being made to *decrease the documentation workload for RNs* were asked to list the kinds of changes that have been made. Listed changes are summarized by employer group in Table C-8, Appendix C (pg. 63). Responses were categorized into the following themes: *Documentation Process Changes; Focused Education; Increased Regulatory Requirements; and RN Perceptions.*

Most of the comments related to *Documentation Process Changes*. In hospitals, comments focused on *computerization* followed by *streamlining forms/processes. Computerization* and *streamlining forms/processes* were mentioned with almost equal frequency by public health respondents. Skilled nursing and home health respondents identified *streamlining of forms/processes* most often followed by *delegation of charting* in skilled nursing facilities and *computerization* in home health agencies. Home health respondents also listed *regulatory requirements* as a major deterrent to reducing the documentation workload.

Promoting Confidence in Management Among RNs. Respondents who answered affirmatively that organizational climate changes were being made to *promote confidence in management among RNs* were asked to list the kinds of changes that have been made. Listed changes are summarized by employer group in Table C-9, Appendix C (pg. 65). Responses were categorized into the following themes: *Administrative Actions; Administrative Structure; Leadership Skills Development; Recognition and Rewards; and RN Organizational Involvement*.

Information sharing, open dialog, and responsiveness characterize the responses in the theme of *Administrative Actions*. *Administrative Structure Changes* were varied by employer group. *Leadership/management training* was listed under the theme of *Leadership Skills Development* by respondents in all groups except public health. *Promotions* were listed by one or more respondents under *Rewards and Recognition* for all groups except Home Health. All groups indicated some type of increased policy or decision-making for staff which is listed under the theme of *RN Organizational Involvement*.

Promoting Respect Among All Health Care Professionals. Respondents who answered affirmatively that organizational climate changes were being made to *promote respect among all health care professionals* were asked to list the kinds of changes that have been made. Listed changes are summarized by employer group in

Table C-10, Appendix C (pg. 70). Responses were categorized into the following themes: *Administrative Actions; Education; Multidisciplinary Activities; Organizational Culture; Physician Interventions; Recognition and Rewards; and RN Organizational Involvement.*

For hospitals, predominant organizational climate changes to promote respect were *teambuilding* and *service standards* within the themes of *Multidisciplinary Activities and Organizational Culture*. Similar changes were listed by home health respondents along with *recognizing individual contributions* (*Recognition and Rewards* theme) *communication/open dialog* (*Administrative Action* theme), and *leadership/ management education* (*Education* theme). Skilled nursing respondents most often responded that the *Organizational Culture* emphasized the *expectation of respect for all.* Among public health respondents, *Multidisciplinary Activities*, *RN Organizational Involvement* and *Recognition and Rewards* themes were mentioned with equal frequency.

Overtime. Respondents were asked if they find it necessary to obtain overtime assistance from current staff on a routine basis to cover patient care requirements. Of the 170 hospital respondents answering the question, 122 (71.8%) indicated overtime assistance from current staff was needed on a routine basis. A higher proportion of high vacancy hospitals required routine overtime than low vacancy hospitals ($?^2$=5.15, *df*=1, *p*=.023). A total of 98 (63.6%) out of 154 skilled nursing, 7 (18.9%) out of 17 public health, and 44 (38.3%) out of 115 home health respondents also answered affirmatively.

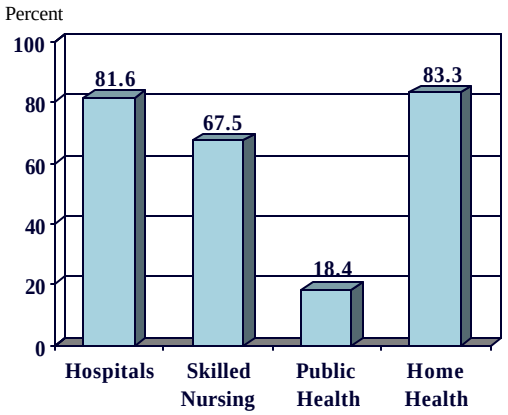
Respondents indicating that overtime assistance was needed from current staff were asked to provide information on their overtime policy. Overtime policy responses are summarized by employer group in Table C-11, Appendix C (pg. 74). Responses were categorized into the following themes: *Administrative Role; Methods of Obtaining Staff;* and *Pay and Incentives.*

Hospital, skilled nursing and home health respondents indicated that overtime primarily was voluntary. Respondents from 24 hospitals (7%) wrote that overtime was never mandatory and 61 (34.5%) stated that overtime was strictly voluntary. Instances in which mandatory overtime could be required were listed by three (2.5%) of the hospital respondents.

Overtime payment at time-and-a half after eight hours and double time after twelve hours was listed most often among the hospital, skilled nursing and home health groups although a variety of compensation methods and special incentives, including bonuses, were mentioned. Public health respondents indicated that overtime was rare and was related to specific program requirements.

Competitive Salaries and Benefits. Respondents were asked if salaries and benefits are competitive at their facilities and agencies. The percent of respondents from each employer group answering affirmatively are shown in Figure 4. Four-fifths of hospital

Figure 4. Percent indicating salaries and benefits are competitive.



and home health, two-thirds of skilled nursing, but less than one-fifth of public health respondents indicated their salaries and benefits are competitive. There were no differences between high and low vacancy hospitals.

Increased Compensation Rates. Respondents were asked if their facilities or agencies had increased compensation rates within the last year for new graduates, newly recruited experienced RNs and/or for current RN employees. The number and percent of respondents by employer group indicating that the agency or facility for which they are answering has increased compensation rates within the specified categories are shown in Table 11.

Table 11. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating that compensation rates were increased within the past year for each of the specified groups of RNs.

Compensation Rate Increases	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
New graduates	140	79.1	84	54.2	9	23.1	NA[a]	--
Newly recruited experienced RNs	146	82.5	99	63.9	10	25.6	75	63.0
Current RN employees	150	84.7	107	69.1	12	30.8	84	70.6

[a] Home health agencies do not employ new graduates.

Approximately 80% of hospital employers have increased compensation rates for all three categories of RNs. There were no differences between high and low vacancy hospitals in any of the rate increase categories. Percentages of employers increasing compensation rates in skilled nursing facilities and home health agencies ranges between 54% and 71%. Public health compensation rate increases were reported in 31% of the agencies or fewer depending on the category of RNs.

Several home health and skilled nursing respondents indicated that their salaries were competitive but their benefits were not competitive with the larger, acute care settings. Home health, skilled nursing and public health respondents indicated their salaries were competitive within their organization type but not with the larger acute care systems.

Options for Rewarding Top Pay Scale RNs. Information on options available for rewarding RNs at the top of the pay scale was requested. Comments are summarized by employer group in Table C-12, Appendix C (pg. 76). Responses were categorized into *Monetary Options* and *Other Options* themes.

Hospital, skilled nursing and home health respondents indicated that *bonuses* were the primary method of rewarding top pay scale RNs. The predominant response from public health was *none*. The *none* response was the second most commonly indicated response for skilled nursing and occurred as a response in all groups. *Wage adjustments* were the second most frequently listed option for hospitals and home health agencies. An *Other Option* listed by respondents in all groups except public health was *promotion* to a managerial position and away from patient care.

Significant Factors Negatively Impacting Ability to Retain RNs. Respondents were asked to list the most significant factors impacting their ability to retain RNs. Listed factors are summarized by employer group in Table C-13, Appendix C (pg. 78). Responses were categorized into the following themes: *Compensation Competition; Facility/Agency Characteristics; Family/Living Issues; Interpersonal Relationships; Opportunities for RNs; RN Characteristics; Scheduling; Staffing/Workload; Support for RNs;* and *Union Activity.*

The primary comment across all groups was *salaries* in the theme of *Compensation Competition*: 20.3% (n=36) of hospitals; 40.6% (n=63) of skilled nursing facilities; 38.5% (n=15) of public health agencies; and 23.5% (n=28) of home health agencies. In all groups except public health, *competitiveness* was also a frequent response. Frequently mentioned reasons in other themes for difficulty with retention included *cost of living* and *shortage of RNs.* Home health respondents also reported that *paper compliance/documentation* was a deterrent to retention.

Best Practices. Respondents were asked to describe a "best practice" related to organizational climate, professional development, or other strategy that has promoted retention of RNs within a unit and/or within the facility or agency. Responses are listed by theme for each employer group in Appendix D, Lists D-1 through D-4 (pgs. 83-91). Responses were categorized into the following themes: *Benefits and Incentives, Career Trajectory, Interdisciplinary Culture, Leadership, Nursing Education, Nursing Practice, Organizational Culture, Recognition, RN Organizational Involvement, Staffing/Scheduling, Support for Professional Growth.*

The wide range of nurse retention "best practices" described by hospital respondents are presented in List D-1, Appendix D (pg. 83). Practices related to *Support for*

Professional Growth were most frequently listed followed by practices related to *Leadership*. Some of the practices related to *Nursing Education* appear to be related to recruitment rather than retention but are included since they were listed as "best practices." Additionally, four respondents indicated that turnover was very low in their facilities and that they had no difficulties with retention. Three of the hospitals were in rural areas and the fourth was a specialty hospital.

"Best practices" described by skilled nursing facility respondents are presented in List D-2, Appendix D (pg. 87). *Working environment* within the theme of *Organizational Culture* was listed most often as a contributor to nurse retention. One respondent indicated that even with an excellent organizational climate, non-competitive salaries force nurses to consider acute care facilities or long-term care competitors with better salary and benefits packages. The result, for this respondent, was decreased work quality, high turnover, increased training costs for new nurses and increased abuse issues. Practices within the theme of *Benefits and Incentives* were listed most frequently after practices related to *Organizational Culture*.

Public health "best practices" are summarized in List D-3, Appendix D (pg. 89). Responses were balanced among many of the themes with emphasis on *Leadership, Nursing Practice, Organizational Culture,* and *Support for Professional Growth*.

"Best practices" described by home health respondents are presented in List D-4, Appendix D (pg. 90). Primary responses related to *autonomy* within the *Nursing Practice* theme as well as responses in the *Leadership* and *Organizational Culture* theme. A wide range of "best practices" were also categorized in the *Recognition* and *Support for Professional Growth* themes.

Additional Comments

Opportunities were provided for respondents to include additional comments related to the recruitment and retention of RNs in their facilities or agencies. Additional comments included by each employer group are presented by theme in Appendix E, Lists E-1 through E-4 (pgs. 92-99). Responses were categorized into the following themes: *Administration, Acute Care Competition,Bureaucratic Inhibition, Nursing Education, Nursing Practice, Organizational Culture, Recruitment Sources and Actions, Remuneration and Recognition, RN Shortage, Staff Organizational Involvement, Support for Professional Growth,* and *Recruitment and Retention Not An Issue*. Both positive actions and areas of concern are included in the themes.

No one theme predominates among the additional comments from hospital respondents (List E-1, Appendix E, pg. 92). Positive actions relate primarily to *Organizational Culture* and *sponsor foreign nurses* under the theme of *Recruitment Sources and Actions* among skilled nursing facility respondents (List E-2, Appendix E, pg. 95). Areas of concern among skilled nursing respondents are reflected predominately in the areas of *Administration, Acute Care Competition, Bureaucratic*

Inhibition, and *Remuneration and Recognition*. Among the additional comments provided by public health respondents, no one theme predominates (List E-3, Appendix E, pg. 97). Positive actions in the theme of *Organizational Culture* and areas of concern in the themes of *Bureaucratic Inhibition* and *Nursing Practice* predominate among home health respondents (List E-4, Appendix E, pg. 98).

Recommendations and Resources

Recommendations. Opportunities were provided for respondents to include recommendations to resolve current nursing workforce issues. Recommendations from each employer group are presented by theme in List F-1, Appendix F (pg. 100). Responses were categorized into the following themes: *Boards of Nursing/Licensure, Compensation, Hiring Issues, Nursing Education, Organizational Culture, Overseas Recruitment, Professional Growth/Support, Public Awareness Ratios, Regulations/Legal Issues, Staffing,* and *Student Recruitment/Support*. The primary recommendations in all groups related to *increasing the number of nursing students and graduates* in the theme of *Nursing Education*. Recommendations to *increase enrollments in current programs, add additional programs, provide support for faculty,* and *recruit students* into programs were evident in all groups.

In addition to recommendations related to *Nursing Education*, hospital respondents most often included recommendations related to the themes of *Ratios* and *Regulations/Legal Issues* (List F-1, Appendix F (pg. 100). No additional theme in addition to the theme of *Nursing Education* predominated among skilled nursing facility (List F-2, Appendix F, pg. 103) or public health agency (List F-3, Appendix F, pg. 105) responses. In addition to recommendations related to *Nursing Education*, home health respondents most often included recommendations related to the theme of *Reimbursement/Regulations* (List F-4, Appendix F, pg. 107).

Resources. Respondents were asked to include suggested sources if financial or leadership resources were needed as part of their recommendations. Resource suggestions are summarized by employer group in Lists G1 through G4 (Appendix G, pgs. 109-110). Employer groups included sources of revenue for their facilities and agencies as well as resources for non-organizational initiatives such as nursing education. All of the employer groups listed state funding as a source of funding for non-organizational initiatives.

Discussion

Several themes related to recruitment and retention of RNs recur within the responses. Across all employer groups, difficulties in remaining competitive with larger acute care facilities and systems in terms of salaries, benefits and incentives was a continuing theme. The need to recruit RNs in hospitals because of the mandated nurse-to-patient ratios was identified by all employer groups as

contributing to the compensation competition. In addition, some facilities and agencies identified their location and cost-of-living issues as contributory under several comment categories.

Comments related to the general shortage of RNs and the need for expansion of nursing education opportunities in California were evident in many of the response areas. Comments related to facilitation of foreign nurse recruitment were included in several areas as well.

Regulatory requirements involving excessive documentation were listed repeatedly by skilled nursing and home health respondents. The impact of the documentation load on both recruitment and retention of RNs was cited.

Best practices and organizational climate changes designed to promote recruitment and retention of RNs were numerous. Responsive leadership, changes in approaches to unit management in hospitals, mentorship and preceptorships as well as other opportunities for RN growth and development, increased RN involvement in the organization, flexibility in scheduling, and recognition programs were listed in multiple areas in addition to attempts to keep salaries and benefits competitive. Many of the listed actions to promote retention and recruitment of RNs are consistent with characteristics of *Magnet* hospitals (McClure & Hinshaw, 2002).

Recommendations presented are consistent with the areas of concern. To address the nursing shortage, recommendations focus heavily on the need for expansion of current nursing education programs and creation of additional programs in California. State support for nursing education was most often mentioned as the source for funding. Recommendations to reduce documentation and revisiting the nurse-to-patient ratios were also frequently mentioned.

Conclusions

- Many of the "best practices" listed are among those shown to be related to recruitment and retention in previous studies and reflect *Magnet* criteria.
- Smaller rural hospitals, skilled nursing facilities public health agencies and some home health agencies are unable to compete with the salaries, benefits and incentives offered by larger hospitals.
- Many non-hospital respondents list salary as a major deterrent to recruitment and retention; they also list "best practices" that positively influence retention and recruitment even though salaries are not competitive.
- The nursing shortage is identified as a major deterrent to recruitment of RNs.
- All employer groups identified expansion of current nursing education programs as well as an increase in the number of nursing education programs as critical to assuring recruitment and retention of an appropriate nursing workforce.

Appendix A
Study Methods

Survey Development

The California Board of Registered Nursing (BRN) Nursing Workforce Advisory Committee (Advisory Committee) had discussed issues of retention and recruitment at their meeting in April, 2003. These discussions were used as a basis for beginning identification of content areas to be included in the survey. A review of literature also was undertaken to identify not only recruitment and retention issues but areas in which best practices were associated with positive recruitment and retention results. A list of the references reviewed is included at the end of the report.

Survey content areas were finalized with the Advisory Committee in November, 2003. As stipulated by the BRN, the survey was designed to have approximately 70 questions with approximately 30 percent having an open ended component. Drafts of the survey and the cover letter were reviewed by BRN staff and a subcommittee of the Advisory Committee. Both an online and print version of the survey were constructed. A copy of the print version is included in Appendix B. The online version was placed on the University of California, Irvine (UCI) Health Sciences intranet. The survey and processes were submitted to the Committee for the Use of Human Subjects in Research at UCI where expedited review status was granted.

Sampling

Employers of registered nurses (RNs) from hospitals, skilled nursing facilities, public health agencies and home health agencies comprised the sample. Mailing labels or databases were provided for the survey by: California Healthcare Association (CHA), California Association of Health Facilities (CAHF), California Association of Homes and Services for the Aging (CAHSAH), California Association for Health Services at Home (CAHSA), and the California Conference of Local Health Department Nursing Directors (CCLHDND). Several of the listings included the name of the Chief Nursing Officer or Director of Nursing for personalized addressing.

A total of 1200 agencies and facilities were included in the sample. The sample included all hospitals provided by CHA (N=395), all public health agencies provided by CCLHDND (N=63), all non-profit skilled nursing facilities provided by CAHSAH (N=116), a regionally stratified random sample of 300 home health agencies from those provided by CAHSA, and a regionally stratified random sample of 326 skilled nursing facilities from those provided by CAHF. The total skilled nursing sample including both the CAHSAH and CAHF samples was 442 employers.

Data Collection

The data collection period was April 19 through June 15, 2004. An initial mailing to the Chief Nursing Officer or Director of Nursing Services included a letter on BRN letterhead with information on accessing the *BRN Employer Survey* online as well as instructions on requesting a print copy, if preferred (Appendix B). The letter included contact information and assurance of anonymity of responses. A follow-up post-card was sent one week after the initial mailing (Appendix B). A second mailing, which included a print copy of the survey, was sent to non-respondents three weeks after the first mailing. A total of 494 responses were received in time to be included in the analyses. Of these, 239 were online responses and 255 were print copy responses.

Final Sample Size

Two skilled nursing employer survey letters were returned to the BRN as undeliverable. Four of the 494 respondents returned surveys or faxed information indicating that their organization either was not yet admitting patients or no longer employed nurses. Two of the agencies were listed as skilled nursing facilities and two were home health agencies. The effective sample for home health agencies was 298 and for skilled nursing facilities was 438. The final sample size was 1194.

Of the 490 valid responses received: 177 were from hospitals (177/395=44.8%); 155 were from skilled nursing facilities (155/438=35.4%); 39 were from public health agencies (39/63=61.9%); and 119 were from home health agencies (119/298=39.9%). The overall response rate was 41.0%.

Responses

Responses to quantitative questions were summarized in tables and charts showing frequencies and percentages of responses within categories. Respondents occasionally repeated items in the "other" category that were included in lists of choices. Repeated items were not listed in the report of *other* items.

Open-ended questions were analyzed for content themes. Similar responses were grouped within thematic categories. In many cases, responses are so unique that individual responses were listed under thematic headings to capture the richness of the data. A series of themes woven throughout the data were identified as areas for further discussion.

Although the survey specifically requests information about RNs, it is possible that respondents for skilled nursing facilities and home health agencies responded to some of the questions in relation to all of the licensed staff, including LVNs. Responses are reported as presented.

Comparative Analyses

Among hospital employers there was considerable variation in the reported RN vacancy rate. A total of 154 respondents for hospitals provided data on vacancy rates. Of thes 30 (19.5%) listed vacancy rates below five percent; 33 (21.4%) of the respondents recorded vacancy rates above 18%. For purposes of comparative analysis, these groups were designated as high vacancy and low vacancy hospitals.

Appendix B

RN Employer Survey

State of California Department of Consumer Affairs

BOARD OF REGISTERED NURSING
P.O BOX 944210, SACRAMENTO, CA 94244-2100
TDD (916) 322-1700
TELEPHONE (916) 322-3350
www.rn.ca.gov

Ruth Ann Terry, MPH, RN

RN Employer Survey

Directions for completing the survey:
1. Please provide either checked responses where check boxes appear or write in your responses where there are lines.
2. Please return the completed survey on or before May 28, 2004 by mail or Fax to: [address deleted]
3. If you have questions about the survey, contact [contact information deleted].

General Information

1. Name of the facility for which you are responding: _____

2. Type of facility:

   ☐ Hospital
   ☐ Skilled Nursing Facility
   ☐ Public Health Agency
   ☐ Home Care Agency
   ☐ Other (Please Specify) _____

3. How many registered nurses (RNs) left your facility in 2003? _____

4. What are the top three (3) reasons why RNs left your facility last year? (Please select 3 reasons)

   ☐ Retirement
   ☐ Termination for poor performance
   ☐ Employer incentives at another facility
   ☐ Personal reasons (such as illness or injury not related to the job, childcare, moving, other family responsibilities, or return to school)
   ☐ Job-related stress, injury or illness
   ☐ Job dissatisfaction
   ☐ Layoffs
   ☐ Other (Please Specify) _____

5. How many RN direct and indirect care full-time equivalent (FTE) positions did you have in 2003?

   _____

6. What percent of your current budgeted RN positions, that you would fill today if you could, are vacant?

   _____ %

7. Do you use traveling RNs?

   ☐ Yes
   ☐ No

8. If you use traveling RNs, what percent of your RN FTEs are covered by travelers? _____%

RN Employer Survey, Continued

9. Do you use local agency RNs?

   ☐ Yes
   ☐ No

10. If you use local agency RNs, what percent of your RN FTEs are covered by agency nurses? _____%

11. Do you expect the demand for RNs to increase over the next three years in your facility?

   ☐ Yes
   ☐ No

12. If you expect the demand for RNs to increase in your facility, will the increased demand be due to: (check all that apply)

   ☐ Market share increases
   ☐ The need to meet nurse-to-patient ratios
   ☐ Increased patient acuity
   ☐ Other (Please Specify) _____

Recruitment

13. Are you experiencing difficulties in RN recruitment at your facility?

   ☐ Yes
   ☐ No

14. If you are experiencing recruitment difficulties, is recruitment difficulty linked to specific specialty areas?

   ☐ Yes
   ☐ No, the recruitment difficulties are in all areas.

15. If recruitment difficulties are linked to specific specialty areas, which ones are they (check all that apply)

   ☐ Operating Room
   ☐ Post Anesthesia Recovery
   ☐ Emergency Department
   ☐ Labor and Delivery
   ☐ Neonatal Intensive Care
   ☐ Postpartum and Newborn Nursery
   ☐ Intensive Care Units
   ☐ Pediatric Units
   ☐ Extended Care Units
   ☐ General Medical Units
   ☐ Surgical Units
   ☐ Orthopedic Units
   ☐ Neurological Units
   ☐ Cardiac Units
   ☐ Outpatient Clinics
   ☐ Long Term Care
   ☐ Home Care
   ☐ Other (Specify) _____

16. If you are experiencing recruitment difficulties, are the difficulties related to specific shifts or hours?

   ☐ Yes
   ☐ No

RN Employer Survey, Continued

17. Are you having difficulty filling RN administrative/managerial positions?

- ☐ Yes
- ☐ No

18. Do you employ a nurse recruiter?

- ☐ Yes
- ☐ No

19. If yes, do you employ the recruiter:

- ☐ Full-time
- ☐ Part-time

20. Which of the following recruitment methods do you use? (Check all that apply)

- ☐ Advertisements in local newspapers
- ☐ Advertisements in statewide newspapers
- ☐ Advertisements in national newspapers
- ☐ Advertisements in nursing newspapers (eg., NurseWeek, Spectrum)
- ☐ Advertisements in nursing magazines
- ☐ Direct mailings to RNs
- ☐ Job fairs, in-state
- ☐ Job fairs, out-of-state
- ☐ Online services
- ☐ Recruitment of nurses from other countries
- ☐ Other (Please specify) _____

21. Which of the following recruitment incentives do you use? (Check all that apply)

- ☐ Housing subsidies
- ☐ Sign-on bonuses
- ☐ Other (Please specify) _____

22. For which of the following do you offer differential pay? (Check all that apply)

- ☐ Evening shifts
- ☐ Night shifts
- ☐ Weekend shifts
- ☐ Baccalaureate degree
- ☐ Masters degree
- ☐ Certification by national organizations
- ☐ Other (Please Specify) _____

23. What recruitment method(s) have been the most productive in your facility to recruit experienced RNs?

_____

_____

24. What are the most significant factors that negatively impact your ability to recruit experienced RNs?

_____

_____

RN Employer Survey, Continued

25. Do you provide clinical experiences for nursing students?

☐ Yes
☐ No

26. Do you formally partner with specific educational institutions as a means of recruiting graduates of the program in ways other than providing clinical experiences?

☐ Yes
☐ No

27. If you formally partner with one or more educational institutions, what is the nature of the partnership?

_____

_____

28. Do you provide financial support directly to one or more nursing education program that prepares new RNs?

☐ Yes
☐ No

29. What special support do you offer student nurses or new nurse graduates as a means of recruitment? (Check all that apply)

☐ Financial support for students in entry-level nursing programs in exchange for a service commitment
☐ Paid externships during the nursing education program
☐ New graduate internships
☐ Extended orientation for new graduates
☐ Mentorship program
☐ Other (Please specify) _____

30. Please provide additional comments you would like to make about the recruitment of new or experienced RNs.

_____

_____

_____

Retention

31. Does your facility allow flexibility in work scheduling?

☐ Yes
☐ No

32. If work scheduling flexibility is allowed, what options are available?

_____

33. Does your facility offer financial assistance for RNs who want to obtain a BSN or advanced degree?

☐ Yes
☐ No

RN Employer Survey, Continued

34. Does your facility provide time off for RNs to obtain further education?

- ☐ Yes
- ☐ No

35. Does your facility provide growth opportunities, such as inservice education, that helps the RN meet license renewal requirements?

- ☐ Yes
- ☐ No

36. If growth opportunities are offered for RNs, please provide examples.

_____

_____

37. In what ways are RNs involved in the organization? (Check all that apply)

- ☐ There is unit-based decision-making
- ☐ There is strong RN representation in committees throughout the organization
- ☐ RNs are involved in all levels of the organization
- ☐ Other (Please specify) _____

38. What models of care are in place in the organization? (Please describe)

_____

_____

39. What is the level of involvement of RNs in quality improvement processes?

- ☐ RNs at all levels are involved in quality improvement processes
- ☐ RNs in leadership positions are involved in quality improvement processes
- ☐ Quality improvement processes are the responsibility of specific RNs
- ☐ RNs are not involved in the quality improvement processes

40. Is consultation from advanced practice nurses and/or peer networks available to staff RNs?

- ☐ Yes
- ☐ No

41. If consultation is available to staff RNs, what kinds of consultation are available?

_____

42. Do RNs have access to online nursing databases and journals from their patient care units?

- ☐ Yes
- ☐ No

43. With which of the following statements do you believe RNs at your facility would agree? (Check all that apply)

- ☐ Nurse leaders in the organization will advocate for their staff
- ☐ RNs have autonomy in their practice
- ☐ The organization is valued in the community
- ☐ All health care providers treat each other with respect

44. Have any organizational climate changes been made to promote feelings of being valued among RNs?

☐ Yes
☐ No

45. If yes, what kinds of changes have been made to promote feelings of being valued among RNs?

_____

_____

46. Have any organizational climate changes been made to decrease concerns about being overworked among RNs?

☐ Yes
☐ No

47. If yes, what kinds of changes have been made to decrease RN concerns about being overworked?

_____

_____

48. Have any changes been made to decrease the documentation workload for RNs?

☐ Yes
☐ No

49. If yes, what kinds of changes have been made to decrease the documentation workload for RNs?

_____

_____

50. Do you find it necessary to obtain overtime assistance from current staff on a routine basis to cover patient care requirements in your facility?

☐ Yes
☐ No

51. If overtime is required to cover patient care requirements in your facility on a routine basis, what is your policy for overtime?

_____

_____

52. Have any organizational climate changes been made to promote confidence in management among RNs?

☐ Yes
☐ No

53. If yes, what kinds of changes have been made to promote confidence in management among RNs?

_____

_____

54. Have any organizational climate changes been made to promote professional respect among all health professionals?

    ☐ Yes
    ☐ No

55. If yes, what kinds of changes have been made to promote professional respect among all health professionals?

    _____

    _____

56. Are salaries and benefits competitive at your facility?

    ☐ Yes
    ☐ No

57. What options are available for rewarding experienced RNs who are at the top of the pay scale?

    _____

    _____

58. Have you increased compensation rates within the last year for new graduates?

    ☐ Yes
    ☐ No

59. Have you increased compensation rates within the last year for newly recruited experienced RNs?

    ☐ Yes
    ☐ No

60. Have you increased compensation rates within the last year for current RN employees?

    ☐ Yes
    ☐ No

61. What are the most significant factors that **negatively** impact your ability to retain RNs?

    _____

    _____

62. Please describe a "best practice" related to organizational climate, professional development or other strategy that has promoted retention of RNs within a unit and/or within the facility/organization.

    _____

    _____

    _____

    _____

    _____

63. Please provide any additional comments about the recruitment and retention of RNs in your facility/organization.

_____

_____

_____

64. Do you have any additional recommendations to resolve current nursing workforce issues.

_____

_____

_____

65. If financial or leadership resources are needed as part of your recommendation, please include suggested sources.

_____

_____

Name of person responding to this survey: _____

Title of person responding to this survey: _____

Area Code and Telephone number of person responding to this survey: (____)___-_____

Please return the completed survey on or before May 28, 2004 by mail or Fax to: [address deleted]

Thank You!

Appendix C

Recruitment and Retention Data Tables

Table C-1. Number and percent of hospital employers (N=177) experiencing difficulty in recruiting RNs in specific specialty areas.[a,b]

Specialty Area	Difficulty in all Areas	Difficulty in Specific Areas	Total for Specialty Area[c]	
	N	N	N	%
Operating Room	54	37	91	51.4
Post Anesthesia Recovery	54	5	59	33.3
Emergency Department	54	52	106	59.9
Labor and Delivery	54	32	86	48.6
Neonatal Intensive Care	54	16	70	39.5
Postpartum & Newborn Nursery	54	4	58	32.8
Intensive Care Units	54	66	120	67.8
Pediatric Units	54	13	67	37.9
Extended Care Units	54	2	56	31.6
General Medical Units	54	29	83	46.9
Surgical Units	54	18	72	40.7
Orthopedic Units	54	5	59	33.3
Neurological Units	54	6	60	33.9
Cardiac Units	54	7	61	34.5
Outpatient Clinics	54	1	55	31.1
Other Listed: Telemetry (N=7) Intermediate/Stepdown (N=6) Rehabilitation (N=5) Psych/Behavioral (N=3) Burn (N=1) Cath Lab (N=1) Total Other	54	23	77	43.5

[a]Nineteen (10.7%) of the 177 hospital employers indicated no difficulties recruiting RNs.
[b]Responses for home care and long term care not included for hospital respondents.
[c]The number of respondents listing difficulty with recruitment in a specialty is added to the 54 hospital respondents indicating difficulty with recruitment in all areas.

Table C-2. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating recruitment methods as being most productive.

Recruitment Methods	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Employee referral (word-of-mouth, networking)	78	44.1	80	51.6	19	48.7	51	42.9
Involvement with local nursing schools[a]	20	11.3	2	1.3	4	10.3		
Job fairs/open house	19	10.7	1	0.6	1	2.6	5	4.2
Website, online services	18	10.2	5	3.2	2	5.1	9	7.6
Direct mailings	14	7.9	--	--	2	5.1	10	8.4
Competitive wages, benefits	12	6.8	6	3.9	1	2.6	1	0.8
Advertising in nursing newspapers	11	6.2	--	--	--	--	2	1.7
Sign-on bonus	8	4.5	3	1.9	--	--	4	3.4
Good work environment	7[b]	4.0	4[c]	2.6	--	--		
Newspaper ads	7	4.0	41	26.5	12	30.8	23	19.3
Foreign recruitment	7	4.0	7	4.5	--	--	1	0.8
Recruitment firms, placement agencies	5	2.8	3	1.9	--	--		
New graduate program	5	2.8	--	--	--	--		
Referral bonus	5	2.8	2	1.3	--	--	2	1.7
Twelve-hour shifts	3	2.0	--	--	--	--		
Transfers between related facilities	3	2.0	--	--	--	--		
Flexible hours, preferred scheduling	--	--	4	2.6	--	--	1	0.8
Other	5[d]	2.8	3[e]	1.9	1[f]	2.6	6[g]	5.0

[a]Includes clinical rotations, extern programs, scholarships, work commitment programs, RN refresher courses, recruitment visits, teaching in schools of nursing.

[b]Includes staff satisfaction, reputation in community, MD-staff relations, adding training programs, Magnet designation, participative management, improvements in work environment.

[c]Includes reputation in community, staff feel "at home," staff longevity, patient-to-staff ratio, facility size.

[d]Includes DVD recruitment video, experience differential, customer service interviewing skills, housing option (closing costs), direct mail to specialty associations, job shadowing.

[e]Includes hiring a traveler, sign outside facility, advertising in church bulletins.

[f]Includes flyers to other health department, job information sharing among peers.

[g]Includes reputation in community, job posting at hospital, in-house bulletin board, "ride-along" for applicants.

Table C-3. Number and percent of hospital, skilled nursing, public health, and home health respondents indicating significant factors negatively affecting recruitment of experienced RNs.

Factors	Hospitals (N=177)		Skilled Nursing (N=155)		Public Health (N=39)		Home Health (N=119)	
	N	%	N	%	N	%	N	%
Salary and benefits	52	29.4	99	63.9	27	69.2	37	31.1
Location[a]	36	20.3	13	8.4	9	23.1	7	5.9
Cost of living/housing	27	15.3	3	1.9	4	10.3	8	6.7
RN shortage	24	13.6	5	3.2	1	2.6	7	5.9
Competition	16	9.0	13	8.4	--	--	8	6.7
Facility characteristics[b]	15	8.5	5	3.2	--	--	--	--
Lack of flexible scheduling, desired shifts	9	5.1	3	1.9	1	2.6	--	--
Lack of incentives	4	2.3	6	3.9	3	7.7	2	1.7
Insufficient nursing educational programs	4	2.3	--	--	1	2.6	1	0.8
Union issues	4	2.3	--	--	--	--	2	1.7
Lack of RNs with needed interest, preparation	4	2.3	9	5.8	10		11	9.2
Nurse registries, traveler opportunities	4	2.3	--	--	--	--	--	--
Lack of advertising, recruitment budget	3	1.7	--	--	--	--	1	0.8
Job responsibilities/paperwork	1	0.6	13	8.4	--	--	13	10.9
Government reimbursement rates	--	--	2	1.3	1	2.6	2	1.7
Travel requirements	1	0.6	--	--	--	--	6	5.0
Time delays for foreign graduate processing	--	--	2	1.3	--	--	--	--
Other	8[c]	4.5	2[d]	1.3	--	--	9[e]	7.6

[a]Includes area in which hospital located, rural area, limited job opportunities for spouse, distance from large city.

[b]Includes size, proximity to larger tertiary center, lack of ICU, older facility with outdated equipment, type of clientele.

[c]Includes hospital being divested, up for sale, corporate processes/marketing, name recognition, declining payor mix, on-call requirements, no benefited low-hour positions, budget constraints.

[d]Includes lack of advancement opportunities, community reputation.

[e]Includes weekend and on-call requirements, associated hospital may close at any time, computerized charting, inability to hire new graduates, new agency, limited job opportunities for spouse, budget constraints, fear of violence in neighborhoods.

Table C-4. Comments by theme and employer group related to recruitment of new or experienced RNs. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one issue.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Applicants	• Insufficient supply (N=4) - increasing supply is the only long-term solution - recruitment sources out-of-state and out-of-country will soon dry up • It is a challenge to find qualified applicants • Hardest to recruit experienced RNs • Salary and bonus expectations are difficulty in a competitive market • Small hospitals need experienced nurses • Have enough new grads • Hard to get experienced RNs who will work nights • Large hospitals attract new grads because of the varied experiences available • Seeing more applicants with histories of negative behavior and performance issues; expect to see more as the shortage continues • Have a good applicant tracking program	• Few apply • Insufficient nurse supply • Difficult to hire • Local RNs are aging • Image of long-term care among nurses • Lack of interest in long-term care unless in management • New grads prefer acute care and 12-hour shifts	• Hard to attract applicants due to rural location (N=2) • Insufficient supply • Applicants have unrealistic expectations due to the shortage	• Title 22 stipulates that applicants must have at least one year of acute or subacute care experience (N=13) • Change Title 22 to allow acceptance of new grads (N=3) • Experienced RNs do not want to deal with home care paperwork (N=2) • Critical care background helpful-need assessment skills for case management (N=2) • Insufficient supply • Want applicants with a year of supervisor experience • Applicants tend to be older or are working home care as a second job • Older RNs are a huge liability to employ • Need case managers but they are not interested in per diem salaries

Table C-4: Comments by theme and employer group related to recruitment of new or experienced RNs (Continued).

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Compensation and Cost of Living	• Scholarships/loans in exchange for work commitment (N=2) • Small/rural facilities without resources for recruitment incentives (N=2) • Impossible for small, rural facilities to match salary and benefits of larger facilities in the city due to low reimbursements for services compared to costs • Cost of living/housing is a critical factor in recruiting and retaining nurses at all levels • A good benefits package has increased recruitment, retention and stability • Sign-on bonuses are not the answer • Registries and traveler agencies offer tough competition related to salary and schedule flexibility • Incentives have created a group of mercenary RNs	• Hard to compete with the hospitals (N=2) • Due to shortage, nurses can move frequently for the best compensation package • Small facilities have limited budgets • Provide free insurance • Paid time off • Decreased working hours • RN salary based on education and experience, but still not great • Need more incentives and free health insurance • Need state help with incentives since RNs difficult to get	• Require a BSN but are unable to compete with hospitals for salary • Limited economic resources in the community	• Recruitment is expensive (N=2) • Cannot compete with salary and benefits packages in large hospitals (N=2) • RNs use appointment letter to negotiate a higher salary with current/other employer • Applicants expect too much money without experience in the field • Plan to develop a scholarship program in the future • Inadequate retirement benefits • Experienced case managers are at a premium – pay insurance immediately instead of requiring a three-month waiting period
Nursing Education	• Expand nursing education state funding/programs (N=5) • New grads lack skill and need a transferable skill set (N=4) • Colleges need to improve selection of students and quality of graduates (N=2) • Need to make nursing attractive to young men and women • More BSNs needed as complexity of care requires more education for critical thinking • No baccalaureate program nearby so 95% of staff are associate degree graduates	• Need increased educational resources from state government to graduate more students - more lab space where lack of space impacts ability to take more students - more applicants than can be accommodated – need more capacity • Small town with no nursing educational programs nearby with which to partner • Geriatric medicine needs to be emphasized	• Increase capacity in the nursing programs • Increase support and flexibility for RNs wanting to achieve the BSN • Encourage nurses to consider public health—dynamic field in which nurses can use talents	• Need to recruit to nursing schools to meet health care needs of population/aging population (N=2)

Table C-4: Comments by theme and employer group related to recruitment of new or experienced RNs (Continued).

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Nursing Education (Continued)	• Student nurse worker program and clinical rotations are main source of new RNs • New RNs unprepared for real working world • Graduates lack of knowledge about Scope of Practice, Title 16, Title 22 • Seeking funding for a graduate internship with a mentorship component	• Lack of understanding of documentation requirements results in difficult job adjustment		
Recruitment Methods	• Have a recruitment program for graduates from local, regional and national Schools of Nursing • Have had better success recently recruiting nurses from other states • Contracted for ten foreign nurses four years ago—still waiting • Need additional discussion about foreign nurse recruitment programs: - technology transfer program to educate future nurses abroad - mandated underserved areas like the MD J-1 visa - expected length of time in U. S. (e.g., five years) - working visas rather than immigrant visas • Seeing more attendees at job fairs coming only for items/food being given away	• Employee referral (word-of-mouth) brings in the best recruits • Advertising is expensive and less effective than two years ago • Sponsor nurses from other countries and provide training	• Government agency–lack resources for incentives, recruitment activities (N=2) • Division personnel officer does the recruitment • Meet with senior students and extend invitation to go directly into public health	• Hospital-wide recruiter (N=2) • Responses are poor

Table C-4: Comments by theme and employer group related to recruitment of new or experienced RNs (Continued).

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Work Environment	• Good experience with new graduate program (N=5) - preceptorships - re-entry RNs can be included - extra support through first year • New graduates receive extended orientation (N=4) • New graduates meet in a support group each week • New grads have not been that successful- insufficient staff to train • Desirable clinical setting for students because of work environment • Hospital know for excellent care and supportive, collegial atmosphere • Strong managers increased stability • Offer prerequisite LVN to RN courses via teleconferencing • Offer re-entry RN programs • Have clinical career pathways and recognition programs • Developing an RN residency program for training and coaching in specialty areas • Small facility with both acute and long-term care patients; RNs must take care of both • Union environment makes recruitment difficult-many RNs do not want union conditions • Retention of new grads after training programs is low-at a significant cost to the facility • Nursing ratios are not the answer	• Adequate orientation (N=5) • Frustrating to train new grads and have them leave after they have gained experience (N=3) • Decreased nurse-to-patient ratio (N=2) • Need a mentorship program • Able to train new grads for skilled nursing facility • Buddy system for new hires • Director of Nurses who is a knowledgeable team player makes a difference	• Flexible schedules have attracted some nurses from the hospital	• Offer good training/orientation • Able to mentor and train new grads on the job if government regulations are changed • If Title 22 changed, accept new grads with a one-year commitment • New hires should be required to sign a two-year commitment • Competency-based orientation decreased turnover

Table C-5. Comments by theme and employer group related to growth opportunities other than inservice education or on-site continuing education. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one opportunity.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Education Support	• Satellite, online, and/or home study continuing education programs (N=19) • Paid or partially paid continuing education/conference days (N=18) • Scholarship/tuition reimbursement/educational assistance program (N=16) • Fees for national certifying organization courses, examinations, and/or recertifications (N=9) • Specific cash amount per year toward formal education/seminars (N=5) • Paid time for specific training programs (e.g., PICC line, OR, ICU) (N=4) • MSN and/or BSN program onsite/through videoconferencing (N=4) • College affiliation to provide education days (N=2) • Online BSN program • School loan repayment • Educational grant information from recruiter • Paid travel for abstracts selected for presentation • Pay for 40 education hours in addition to mandatory hours • Conference tuition assistance • Fund annual education hours • Loans to travel to seminars • Regional conferences offered on-site in trauma, ICU, cardiac care • Online access to nursing journals	• Fees for off-site continuing education courses/seminars/ workshops (N=40) - up to a certain amount - some budget for off-site seminars - every nurse goes to at least one off-site seminar a year • Management training (N=11) • Training costs for certifications such as MDS and DSD (N=4) • Paid time off for seminars (N=3) - three days per year • Flexible work schedule to support school schedule (N=2) • Time off for seminars (N=2) • Satellite, online, and/or home study continuing education programs • Pay RN license renewal fees • Time off for classes • Staff encouraged to continue education	• State-sponsored training seminars (N=14) • Specified amount of time and funding to attend seminars or conferences (N=5) • Tuition/textbooks/time for advanced education (N=4) • Pay for work-related training and seminars, including travel (N=4) • Arrange work schedules to accommodate classes (N=2) • Organized regional conference on topic of current concern (N=2) • Scholarships/information in ADN program to encourage BSN to PHN pathway • Leadership development program • Satellite, online, and/or home study continuing education programs • Staff development committee	• Reimbursement for specialty courses/specialized certification programs (e.g., hospice, case manager, wound-ostomy care) (N=7) - partial payment • Satellite, online, and/or home study continuing education programs (N=5) • Pay for staff to attend conferences (N=5) - work-related • Leadership/management courses (N=4) • Mentorship/preceptorship programs (N=3) • Send RNs to training programs in support of agency needs • Flexible work scheduling to accommodate classes • Send RNs to NAHC and CAHSAH events

Table C-5: Comments by theme and employer group related to growth opportunities other than inservice education or on-site continuing education (Continued).

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
In-House Targeted Programs	• Certification programs (e.g., PICC line, wound care, ACLS, PALS) (N=20) • Specialty training/cross-training for emergency department, labor and delivery, operating room, post-anesthesia care, critical care, and/or pediatrics (N=29) • BLS instructor program • Cardiac symposium • Leadership/management classes (N=15) • Preceptor training (N=6) • Team building classes • Journal club • Evidence-based practice research • Professional nursing institute	• Certification classes (e.g., IV, PICC lines, wound care) (N=12) • Work with RN supervisor to gain experience		• Certifications (e.g., IV,PICC) (N=2)
Recognition for Growth	• Clinical/career ladder program (N=8) • Promotion to management positions (N=6) • Career development paths for preceptor, mentor, charge nurse, clinical educator, clinical manager • Pay differential for higher education	• Promotion to management position (N=9)	• Promotion	• Financial recognition to RNs with demonstrated increased clinical expertise and involvement in non-normative activities, such as special projects. • Promotion to leadership/managerial positions (N=5) • Career ladder

Table C-6. Comments by theme and employer group related to promoting feelings of being valued among RNs. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
Addressing RN Concerns	• Staff satisfaction/opinion surveys (N=9) - action plans based on results - unit-specific improvements based on survey feedback - demonstration of results from satisfaction survey - focus retreats • Staff meetings/forums, more regularly held, response to staff concerns (N=8) • Recruitment/retention/ environment committees to address concerns (N=3) • Extensive employee satisfaction program • Administrative members meet RNs on any shift at RN request	• Weekly staff meetings (N=2) • Monthly RN meetings • Regular licensed meetings with open discussions	• Regular staff meetings (N=2) • Regular upper management meeting with supervisors - ideas/thoughts on services provided • Peer groups • Monthly potluck and networking session with inservice	• Staff meetings (N=5) - all RNs have input - brainstorm workflow processes • Staff surveys with work group follow-up to develop action plans to improve work • Employee Advisory Committee • Employee satisfaction program • Employee work experience surveys • Increased opportunities to communicate ideas
Administrative Actions	• Open-door, open communications with nursing administration (N=8) - excellent accessibility - one-on-one meetings • New nursing leadership/changes in management (N=5) • Magnet status/seeking Magnet status (N=5) - and culture that surrounds it • Leadership training/academy (N=4) - related to values program • Customer service program/ training (N=4) • Directed efforts at retention (N=3) - nurse managers as retention officers - hired a retention coordinator	• RNs regarded and addressed as supervisors (N=2) • *Mather Lifeways/LEAP* program (N=2) • Open communication • Administrative support for management decisions made • More support from management • New Director of Nursing • New management • Work-related activities with staff/supervisors	• Open communication with supervisors (N=2) • Strategic planning initiative (N=2) - focus groups with outside consultant • Not much/poor support from management outside of nursing (N=2) • Support from PHN Director • Director of PHN nursing provides leadership for all nurses, regardless of program affiliation • Change in nursing leadership	• Change in administrator (N=3) - committed to staff - increased communication with CEO • Change in nursing leadership • Good leaders • Seeking/attaining Magnet status • *FISH*! philosophy • Weekly voicemail messages to update staff on any changes, concerns, issues, successes • *Seeds of Excellence* program • Conversion to computerized documentation • Open-door policy

Table C-6: Comments by theme and employer group related to promoting feelings of being valued among RNs (Continued).

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
Administrative Actions (Continued)	• Values/core values program (N=2) • Administrative stability (N=2) • Change in company ownership with RNs now in top management positions • Corporate program • Flattened management between CNE and staff to increase visibility and access • Recentralized nursing • Collaborative management model in nursing department • Participative managers • Development of nsg strategic plan • Developing learning environment • Restructuring of management positions to increase unit support • Implemented *FISH*! philosophy • *Great Place to Work* initiative • Management participation in staff meetings • Training of managers in mentoring and coaching • Senior leadership support • Consultants for staff development • Quarterly info sessions • Adoption of *Total Quality Management* • Management rounding • Consultants for staff development • Collegial climate • Goal-oriented model for patient, staff and physician satisfaction • Organizational realignment • Leadership evaluation by staff • Elimination of preferential treatment practices • Commitment to remain union-free • Raised the bar			• Started F.I.S.H. (Fresh Ideas Start Here) program • Culture of corporate and team respect • Staff encouraged to provide input regarding policies, processes, budget and general operations • Decreased documentation • Home fax for assignments • Promote staff wellness

Table C-6: Comments by theme and employer group related to promoting feelings of being valued among RNs (Continued).

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
Interdisciplinary Relationships	• MD-RN summit meetings (N=2) • Interdisciplinary bridge-building • Unit-specific MD/RN relationship building • Expect MD peer support for RNs-work to manage MDs who create hostile/abusive environment • Working on disruptive MD behavior policy • Physician relations committee to handle issues with MD behavior • Published *Standards of Behavior*			
Patient Care Focus	• Communicate message that nurses are partners supporting safe patient care • Changed to patient-centered team care • Interactive education related to patient/practice concerns • Focus toward excellence in patient care • Communication of patient satisfaction scores			• More focus on excellence of care

Table C-6: Comments by theme and employer group related to promoting feelings of being valued among RNs (Continued).

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
Recognition Programs/Strategies	• Individual recognition (e.g., written/public recognition for excellence, quality service awards, financial awards, on-the-spot recognition, *Nurse/Employee of the Month*, *Nurse of the Year*, statuette/plaques to nurses of distinction, service excellence program, *Hero* awards, *Exemplar* awards, unit-level individual recognition program, acknowledgement based on results of patient satisfaction surveys, excellence awards presented at a gala, career ladder advancement celebration, *Values in Action*, monthly recognition of unit-based role model, perfect attendance awards, large photos of caring nurses throughout hospital) (N=36) • General staff appreciation (e.g., public recognition by administration, *Nurses Week* celebrations (elaborate) and gifts, thank-you letters sent to nurses' home from CEO or CNO, staff appreciation events, float thank you, breakfast/lunch with CEO, tea with CNE, special lunches and dinners, free meals) (N=11) • Constant/extensive/increased recognition program (N=4) • Special attention to recognition of nurses on night shift • Recognition program includes nursing staff and physicians • Small facility/ feeling of family • Newsletters • Respect	• Individual recognition (e.g., recognition for quality work and interventions, newsletter with recognition for RNs, *Employee of the Month*, recognition board for staff/ consumers to see, years of service ceremony) (N=9) • General staff appreciation (e.g., birthday celebration, annual/*Nurses Week* appreciation/celebration/ recognition, gifts, barbecues, lunches, parties, pizzas) (N=9) • Feeling of belongingness/family (N=2) - close-knit group - take pride in facility • Many nursing appreciation rewards	• Individual recognition (e.g., continual effort to recognize each individual's contribution to community health, instant recognitions, more positive reinforcement, individual staff *thank-you's* at the end of clinic, monetary incentives for reaching certain goals, *Employee of the Month, Quarter, Year*) (N=4) • General staff appreciation (e.g., *Nurses Day* always remembered) • Building strategies	• Individual recognition (e.g., positive feedback, recognition for excellent performance, *Employee of the Month/Quarter*, *Applause Cards*, on-the-spot recognition, thanks for input, *Shining Star* award for valued performance, Board presentations; thank-you notes; *Daisy* awards) (N=15) • General staff appreciation (e.g., Nurse *Appreciation Day; Nurses Week* celebration, *Home Health and Hospice Week* celebrations; parties; office celebrations, newsletters, gifts, events throughout the year) (N=15) • Reward/ recognition program (N=6) - includes good work from co-workers, management and external sources - strong program • Respect

Table C-6: Comments by theme and employer group related to promoting feelings of being valued among RNs (Continued).

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
RN Organizational Involvement	• Shared leadership, shared governance, unit-based nursing councils (N=7) • QI involvement, including establishment of interdisciplinary QI teams (N=4) • Professional practice forum/council/committee (N=6) - clinical and non-clinical sounding boards - hospital-wide addressing education, practice, quality and research • Increased RN involvement on committees/decision-making (N=6) - *Health Care Groups* with RN as leader/member - encourage involvement in PI committee • Partnership Council/Committee • Direct involvement in PI monitoring • Encourage involvement in decisions about care delivery system • Strong Union/management RN Committee • Input into equipment purchases, remodeling • Nursing research council • Empowerment	• More involvement in policy/ decision-making (N=9) - related to quality of patient care issues - building systems design • Empowered to make management decisions within boundaries given • Daily resident rounds • Committee to modify documentation format • Special projects model for improvement • More responsibility • All staff involved in CQI initiatives	• Department steering committee • All staff encouraged to participate in short term committees	• Decision-making, operational involvement and input (N=8) - increasing - related to care provided - autonomy - seeking creative ideas from RNs • Self-direction/independent decision-making (N=2) • Empowerment (N=2) • Involvement in QI committee • Collaborative (team) decision-making • Active involvement in interdisciplinary process • *Point of Service* task forces • RNs involved with the case management team • Nursing visioning meetings

Table C-6: Comments by theme and employer group related to promoting feelings of being valued among RNs (Continued).

Theme	Hospitals (N=130)	Skilled Nursing Facilities (N=44)	Public Health Agencies (N=19)	Home Health Agencies (N=67)
Salary and Benefits	• Increased salary (N=7) • Annual salary survey/market adjustments (N=3) • Review of benefits package • Bonus/salary adjustment for preceptor (N=2) • Salary adjustment for unit lead	• Increased salary (N=4) • Bonuses (N=2) • Increased benefits	• Added senior PHN job description • Encouraged to ask for pay raises	• Incentive program (N=5) • Increased salary (N=3) • Bonuses (N=2) • Strong pension plan (RN request) • Increased benefits • Gas card
Staffing	• Retain CNAs (2) • No mandatory floating - $5 above base for voluntary floating • Shift options • Clinical support • In-house registry (N=2) • Ratios (N=2) • Additional CNSs to help with practice standards • Additional case managers	• Staffing assistance		• Added supervisors • Added *OASIS* coordinator • Staffing support
Support for Professional Growth	• Clinical ladder/modified clinical ladder (N=5) • Mentor/Preceptor programs (N=3) • RN-BSN program • Scholarships for BSNand MSN education • 40 hrs. of education time/year • Commitment to education and professional development • Numerous educational opportunities to address individual needs/goals (N=3) • Development of charge nurse role • Leadership preparation for charge nurse/unit lead (N=4) • National conferences as basis for improvement projects • Additional CEU offerings • Patient care forums/issues updates • Increase in education benefits • No-cost continuing education • Incentives for higher education	• More education opportunities (N=5) - inservice education - stress management classes • Promote from within • Encouraged to increase leadership skills • Opportunities for outside seminars	• Monthly inservice with staff meeting (N=2)	• Increased education programs (N=3) - inservice education - communication/grieving • Preceptor program • Clinical ladder • Leadership classes • Tuition reimbursement

Table C-7. Comments by theme and employer group related to decreasing RN concerns about being overworked. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=49)	Public Health Agencies (N=4)	Home Health Agencies (N=45)
Staffing	• Ratios (N=35) - strictly observed - staffing exceeds ratios in some areas - 4:1 ratio in med-surg - meeting ratios to the best of our ability - hardship due to isolated location - instituted prior to required timeline - reduced number of patients for new grads, first 6 months • Variety of/increased numbers of teams/unlicensed staff (e.g., added LVNs, CNAs, unit techs, ward clerks, lift techs/teams, transport employees, blood draw tech, PICC line placement, bath team, *helping hands*) (N=19) • Added RN staff/managers (e.g., lead RN, charge nurses, clinical coordinators, resource RNs, supervisors, unit-based educators, advanced practice nurses, management staff to assist in critical thinking, clinical mentors) (N=15) • In-house registry/float pool (N=8) - increase numbers - cross-training of some staff - minimizes floating by senior nursing staff - pre-fill vacancies with in-house registry, also travelers • No mandatory overtime (N=4)	• Increased RNs and/or number of support staff (e.g., treatment nurse, LVNs, clerk/med secretary) (N=13) • Reoganization of assignments/responsibilities (N=10) - efforts to spread work more evenly among staff - reassign non-medical duties to support staff - RN positions substituted with LVNs • Not an issue (N=10) - have enough RNs on staff - DON helps when workload increased - RNs, LVNs work well together, carry same load - RNs work 8 hrs, supervisory only • Hours adjustment/flexible scheduling (N=5) - 4-day week option - split shifts - requested time off • Changed the staffing model (N=2) - decreased ratio of residents to RN • Team nursing model • RNs work well together, self-schedule • Flex staff to meet workload • Using agency RNs to replace positions	• Not a concern (N=2) - RNs set own agenda - RNs cover for each other • Project support resources (e.g., clerical) made available as possible for projects • Look for funding sources to expand staff – State budget issues past two years have countered every attempt	• More staff (N=10) - full-time staff to decrease number of patients on a caseload - per visit/per diem staff - weekend and on-call RNs - need part-time RN to help with field cases - full-time evening and night nurses - relief RNs • Flexible scheduling (N=7) - work as much or as little as desired - optional overtime - most staff work 4-day week - required to work one weekend per month - not required to take call • Assignment of clerical and delivery duties to support staff (N=6) • Change in productivity standards with prospective payment system (PPS) (N=4) - budget based on productivity expectations - RNs have no control related to these standards - productivity and paperwork are focus • Added non-clerical ancillary staff (N=3) • Potential referrals accepted or rejected based on RN workload (N=2)

Table C-7: Comments by theme and employer group related to decreasing RN concerns about being overworked (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=49)	Public Health Agencies (N=4)	Home Health Agencies (N=45)
Staffing (Continued)	• Travelers/long-term registry (N=4) - when census high • On-call system for assistance if need arises (N=3) - on-call night position • Not an issue (N=3) - excellent staffing system provides staff when needed - majority of staff has not felt overworked • Clinical assistance from charge RNs/nurse managers (N=2) • Charge nurse not counted in ratios (N=2) • Increased nursing hours per patient day (NHPPD) • Maintained numbers of CNAs when implemented ratios • Change from RN/CNA to RN/LVN mix • Housewide staffing strategies to balance RN availability • Team nursing • Staff input into staffing • Nurses have authority to call in extra staff as needed • Lunch and break relief • Staffing needs continually addressed • Implementing automated scheduling system • Plans for online shift bidding to fill vacant shifts • Self-scheduling • Flexibility in scheduling			• Staff paid per visit (N=2) - in control of own caseload/ visit volume - limit number of visits per day • Paperwork days (N=2) • Decreased patient load and number of visits • Work hard to keep RNs to an 8 hr shift to avoid overtime • Revised staffing patterns • Caseloads reduced during phase-in of electronic documentation • Have patient-to-nurse ratios • New management company has cut staffing • Have been unable to hire an RN to fill a new full-time position

Table C-7: Comments by theme and employer group related to decreasing RN concerns about being overworked (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=49)	Public Health Agencies (N=4)	Home Health Agencies (N=45)
Streamlining Work Processes	• Decreased paperwork (N=6) - computerized documentation - automated reporting, shift-to-shift - automation of ICU documents - electronic Kardex • Wireless/cell phones (N=3) - for nursing staff in key areas • New care delivery model • Automated supply and medication dispensing cabinets • New equipment	• Changed documentation system/decreased documentation (N=2) • Systems review and processes simplification • Moving toward computer-based data management system • Modernizing equipment • Pharmacy with bubble pack only		• Decreased/consolidated paperwork (N=5) - computerized documentation • Changing some process to use more pre-printed handouts • Centralized patient management • Streamlining processes to increase time in direct care • All RNs have cameras, scales to decrease office trips • Buddy system to transport paperwork to office
Addressing RN Concerns	• Group meetings/forums/unit-based discussions (N=8) - unit-based when needed - monthly with charge nurse - collaborative management meeting with clinical nursing directors • Nursing Advisory Board advocates for nursing issues with CNO • Nurse liaison committee • Flexible meetings/freedom to discuss concerns with appropriate and timely follow-up • Breakfast/lunch/dinner meetings with RNs and CEO/administration to obtain feedback about workload and workflow • Nursing process team to make positive changes • Staffing model committee • Focus groups on documentation challenges, bar code medication administration (BCMA)	• Increased support, decreased responsibility • Employee assistance program	• Overwork issues discussed in meetings - exercises and support during meetings for stress management	• RNs involved in processes to streamline workload • Nurse-run efficiency task force to review point-of-service devices • Performance improvement teams • Open discussions of caseload evaluation of on-call service flexibility for full-time and part-time personnel • Meet to work through hot topics such as productivity

Table C-7: Comments by theme and employer group related to decreasing RN concerns about being overworked (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=49)	Public Health Agencies (N=4)	Home Health Agencies (N=45)
Administrative Actions	• Increased recruitment (N=4) - new grads - foreign grads - filling vacant positions • Frequent/daily rounds by nurse exec (N=2) • Open door policy with management (N=2) • Leadership worked to increase support department performance • Increased management skill and communication • Leadership vacancies filled • Introduction of service excellence program • Improved teamwork on units • Development of interdisciplinary partnership councils • Greater accountability for support departments • Validating productivity tool • Ongoing support • Positive support system • Flexible in life situations	• Better support from leadership (N=2) • Teambuilding in all departments • Improved communication	• Strategic planning • PHNs do not appear to be valued by non-nurse directors/managers - do not actively recruit RNs - advocate for non-nurses to run clinics/programs that should be run by nurses for their expertise	• Management staff participate in patient care, on-call rotation, weekends (N=2) • Increased communication about agency finances • Continuing recruitment • Listening to staff concerns • Good leadership • Administrators provide support so nurses can do patient care • Respect for RN's family responsibilities
Patient Acuity	• Implementation of patient flow program (N=2) • Revising patient classification system • Adjustment to hours of care based on acuity assessment • Sophisticated patient classificiation/productivity management system to staff by patient acuity - drives nursing budget • Consideration of acuity pre-admission and census holding if necessary for nursing	• Re-evaluation of acuity levels • RN input into adjusting facility population to balance acuity	• Budget limitations influence decisions/retooling to target at-risk groups changing who is served	

Table C-7: Comments by theme and employer group related to decreasing RN concerns about being overworked (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=49)	Public Health Agencies (N=4)	Home Health Agencies (N=45)
Focused Education/ Training	• Education sessions (N=3) - Scopes of Practice - Ratios - Team/modular nursing model • Training for shared governance • Mentoring/staff development in critical thinking			• Prospective payment system (PPS) and how nurse is integral to organization finances
Recognition and Appreciation	• Staff are thanked, given general praise often • Funds for managers to reward staff			
Role Benefits	• Charge nurse role added to clinical ladder • Preceptor pay			• Increased salaries • No raises in two years • Opportunities for promotion

Table C-8. Comments by theme and employer group related to decreasing the documentation workload for RNs. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=102)	Skilled Nursing Facilities (N=51)	Public Health Agencies (N=15)	Home Health Agencies (N=67)
Documentation Process Changes	• Computerized documentation/ electronic record (N=64) - moving toward/planning for computerization - available in some units (e.g., ICU, L & D) - available for some departments (e.g, radiology, laboratory, dietary) - computerized bedside charting with templates - new health information system - electronic template notes for routine charting - hand-held devices for limited electronic documentation - automatic referrals, message capability, ordering - *Documentation Task Force* • Streamlining of forms/process (N=34) - eliminate duplication/redundancy - eliminate unnecessary data - redesign forms - forms consolidation at unit level - reduced multiple forms to one 24-hour flowsheet - including checklists - corporate form changes - standardization of forms - continually refining • Checklists/checkboxes (N=10) - Check boxes unless exceptions - RNs on committee making changes	• Streamlining of forms/process (N=19) - eliminate duplication/redundancy - changed forms - new charting system - new form for weekly summary - facility still compliant with requirements - chart once/day for Medicare rather than every shift - review and revision of forms - streamlined assessment - streamlined flow sheets - corporate nursing notes form • Delegation of charting (N=10) - desk nurse - unit/ward clerk inputs MD orders - LVN hired to do charting for RN to review and sign - Extra LVN to help most of the time • Computerized charting (n=6) - for Minimum Data Set (MDS) - unit clerks do computerized data entry - medical records does computerized data entry - computer literacy difficult	• Computerized data collection/documentation (N=8) - time sheets - patient documentation - some - working toward - handheld devices in the field • Streamlining of forms/process (N=7) - eliminate duplication/redundancy - new flow sheets • Checklists (N=2) • Documentation by exception (N=2) • Clerical assistants hired to help with paperwork burden • Extensive use of email network • Standard protocols	• Streamlining of forms/process (N=33) - eliminate duplication/redundancy - new forms/paperwork - continually looking for ways to streamline documentation - OASIS paperwork recently changed - for forms that do not require OASIS - decrease repetitive paperwork while meeting regulations - *Forms Committee* to consolidate/change forms - RN input into changes • Computerized documentation/ electronic record (N=25) - online - documentation is on laptops - program being revamped to make it more user-friendly - new clinical software package - point of care/service system - handheld devices - field devices for all clinicians • Checklists/checkboxes (N=6) - new forms/paperwork - checkmarks on care plans

Table C-8. Comments by theme and employer group related to decreasing the documentation workload for RNs (Continued).

Theme	Hospitals (N=102)	Skilled Nursing Facilities (N=51)	Public Health Agencies (N=15)	Home Health Agencies (N=67)
Documentation Process Changes (Continued)	• Charting by exception (N=8) • Clinical pathways/carepaths, care maps, protocols (N=3) • Increased numbers of flow charts (N=3) • Redesigning/streamlining nursing database/care system (N=3) • Computerized care plans (N=2) - interdisciplinary • Re-constructed admission assessment but still too long • Standardized patient education materials • Exploring several technologies • Pre-printed order forms • Already streamlined, standardized	• Checklists (N=4) • Use more diagrams • Template charting • Extra RN hired to do admissions • Hired additional nurses to help with documentation • Department heads take some of the documentation responsibility • New corporate owner has decreased documentation as a goal • Division of patient charting by each shift • Focus on MDS-driven care plan • Changed medication order system		• Documentation decided at the corporate level (N=2) • OASIS burden decreased for private pay and re-certifications (N=2) - no admit OASIS for non-Medicare patients • Decreased narrative note • Purchased comprehensive documentation package • Clerical assistance for paperwork processing • Managers write office patient discharges
Focused Education	• Working more efficiently • Change management consultants for new computerized system			
Increased Regulatory Requirements	• More need to document now that ratios are in place	• Are you kidding? Decreased documentation impossible with government mandates • Survey usually results in more documentation	• Increasing accountability to document effectiveness of nursing/interventions	• Medicare, State, Joint Commission (N=11) - requirements are set - it only increases - more appears to be better - cumbersome amount of paperwork - overwhelming - limited ability to decrease - talk to Centers for Medicaid/Medicare (CMS)
RN Perceptions	• RNs do not perceive a decrease in documentation • With computerization, initially it takes more time • It seems to be more, not less	• Documentation workload is worse than acute care		• Regulatory requirements are a deterrent to those interested in home care • Paperwork too huge

Table C-9. Comments by theme and employer group related to promoting confidence in management among RNs. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=45)	Public Health Agencies (N=10)	Home Health Agencies (N=57)
Administrative Actions	• Management/leader rounding (N=16) - safety culture - visibility - availability to staff • Open forum/open dialog (N=15) - with CNE - with CEO - all shifts - quarterly • Sharing of information by administrators (N=9) - at staff meetings - frequent updates - informational forums - newsletter - *State of Facility* report from CEO • Management meetings with staff (N=8) - frequent meetings - series of meetings to explore issues and their resolution • Staff satisfaction survey (N=6) - completed every quarter/yearly - concerns addressed, results reported back to staff • Open door policy (N=5) - approachable managers • Respond to employee concerns in a timely manner (N=4) - within 24 hours - follow-through on issues • Improved communication (N=2) - at Department Directors meeting - top down	• Sharing of information by administrators/management (N=6) - monthly/weekly meetings with RNs - quarterly info sessions with CEO - monthly license meetings • Open door policy (N=5) - direct access to DON • Open forum/open dialog (N=2) - request a *speak easy* meeting with DON/Administrator - frequent meetings with requests for feedback • Management more visible (N=) - meeting with staff on all shifts • Changes made in response to staff requests • Better communication • Increased number of feedback systems • Evaluation of RN workload • Employer support • Fair treatment • Scheduling assistance • Special inservices to bring nurses together as a group	• Frequent meetings with staff • Support from nursing leadership but not from non-nursing director/admin staff • PHN managers acknowledged as key leaders in specific regional service areas by administration - communicated to staff at brown bag lunches	• Open door policy (N=8) - access to managers without barriers - visiblity • Sharing of information by administrators (N=7) - by CEO on state of the agency - keep everyone informed - on a daily basis - staff given information on all changes/progress - newsletter - related to the mission and its affect on patient care - when possible • Management meetings with staff (N=3) - on-call by RNs - regular meetings/ - by CEO • Employee satisfaction survey (N=3) - follow-through on issues • Open forum/open dialog (N=2) - monthly - increased number • Increased visibility (N=2) • Participatory management • Mid-level managers do direct care • Support from nursing leadership but not from non-nursing director/admin staff

Table C-9. Comments by theme and employer group related to promoting confidence in management among RNs (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=45)	Public Health Agencies (N=10)	Home Health Agencies (N=57)
Administrative Actions (Continued)	• Manager/charge nurse meetings • Managers meet quarterly with individual staff nurses to hear their ideas • CEO empowers departments, compliments everyone, changed negative to positive attitudes • Increased presence of managers on units • Senior leadership involved more often in events for night shift • Nurse managers perform care with staff • Decreased responsibilities to increase time on units with staff • Implemented service line concept to improve patient movement • Committed to obtaining Magnet status • Blame free environment • Equality climate • Unit needs addressed immediately with documentation of action • Philosophy of care statement developed - also statements about removing barriers to care • More participative management • Nurse administrative team meets regularly with CEO - includes DON, nurse managers • Succession planning			• Management respect for clinical expertise • Extra support from corporate • Focus groups to identify issues • Obtain RN input on case management • Parties, organizational functions to promote confidence • Good working environment

Table C-9. Comments by theme and employer group related to promoting confidence in management among RNs (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=45)	Public Health Agencies (N=10)	Home Health Agencies (N=57)
Administrative Structure	• Change in leadership (N=12) - new CNO - new VP of nursing - new directors • Hired more managers/unit directors (N=6) - more accessible - more visible - one for each unit - frontline managers • New CEO (N=4) • Nursing management restructuring/re-design (N=4) • COO is an RN (N=2) • Nursing care delivery restructuring (N=2) - with input from RNs • CEO is an RN • Created charge nurse role • New Director of Education • New COO • New position, Director of Nursing Staff Services • Change in entire administrative staff	• New ownership/ administration - have made great strides • New DON (N=3) - RN with masters degree • DON member of management team • Increased support staff • Nurse managers in each unit • Director of Health Services position created	• RN leaders instead of lay administrators	• Hired competent, strong management staff • Aggressively recruiting additional nursing staff • New Educator • New Office Manager • Organizational Development position • Added RN Supervisor to support branch staff • Personnel changes • Qualified staff to share work • Replaced ineffective management staff • Organizational restructuring - new leadership focused on communication, teamwork, professional expectations • Elimination of Home Care Department by hospital with subsequent ability of management team to secure support establishing a free-standing agency - everyone able to keep job
Leadership Skills Development	• Leadership/management training (N=26) - based on 360 assessment - ongoing/quarterly - development programs - in trust-building/communication - in fairness and equity - from national consultation company - competency training - training to assure consistency - *Nurse Leadership Academy*	• Leadership/management training (N=8) - inservice - seminars for specific skills - encourage and pay for classes		• Leadership/management training (N=12) - massive effort last 2 yrs - conference on leadership styles - ongoing inservice program - for case managers - workshop series for managers - seminars - from coporate, with CEUs

Table C-9. Comments by theme and employer group related to promoting confidence in management among RNs (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=45)	Public Health Agencies (N=10)	Home Health Agencies (N=57)
Leadership Skills Development (Continued)	- among managers - for staff - for unit coordinators - development of charge nurses - mid-manager training - *Nurse Executive Center* - Advisory Board seminars - Corporate training - team-building - classes for all staff • Department supervisor meetings with education and training • Quarterly management/leadership conferences for all dept. managers • Fun activities promote teamwork among departments • Encouraged to take advanced management classes			
Recognition and Rewards	• Thank-you notes (N=3) - to nurses' homes • Promotion from within (N=2) - Encourage charge nurses and supervisors to move into management positions • Increased salaries • Increased pay incentives for nurse managers • Staff appreciation days • Increased number of education days • More CEU offerings • Revised reward system	• In-house promotion to higher management levels (N=2) • Bonus/incentive • Positive recognition • Inservices and continuing education	• Promotions	

Table C-9. Comments by theme and employer group related to promoting confidence in management among RNs (Continued).

Theme	Hospitals (N=113)	Skilled Nursing Facilities (N=45)	Public Health Agencies (N=10)	Home Health Agencies (N=57)
RN Organizational Involvement	• Increased involvement in decision-making (N=6) - input into organizational goals • In project implementation/QI processes (N=3) • *Nurse Champions* (select group of RNs) meet each month • Beginning discussions on professional practice model • Recentralization of nursing • Leadership teams headed by RNs • Participate in interviews for new managers • RN Retention Task Force • RN staff included in *Nurse Council* • Interdisciplinary progress notes • Expectation of professional involvement • Negativity/division in ranks due to union activity	• Greater participation of RNs in planning and policy development • Involvement in systems evaluation and redesign • Buddy system • Seminars and workshops to encourage new ideas	• Strategic planning process addressing community need and underserved areas	• Increased involvement in decision-making (N=3) - RNs empowered to make decisions affecting them • Program development and standards of care • *Employee Advisory Committee* • Involvement in task forces, meetings • *Efficiency Task Force* run by clinical staff

Table C-10. Comments by theme and employer group related to promoting professional respect among all health professionals . Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=106)	Skilled Nursing Facilities (N=50)	Public Health Agencies (N=19)	Home Health Agencies (N=53)
Administrative Actions	• Open forums/town hall meetings (N=2) • Meeting with staff regarding respect • Setting limits with interactions • Positive reinforcement of appropriate behavior; intervention if behavior inappropriate • *Leadership Committee* to discuss issues • Retreat days with staff from all levels of organization • Employee survey • Encouraging and supporting empowerment • All patient care services report to CNE who meets with groups regularly • Executive walk-arounds • One-on-one meetings • Exec communications given three times rather than once, then go to each unit to meet with staff and leave copy of slides/handouts. • New COO position with participatory style • Patient safety projects • Social events (e.g., staff barbecues)	• Meetings (N=2) - monthly license • Employee satisfaction surveys • Team meetings - weekly - share concerns and problem solve • Leaders as examples for teamwork • Daily contact with staff • Fostering a climate that values staff input • Removing staff who do not promote professional respect among all health professionals • Unit managers encouraged to delegate • Daily meetings with all dept. heads, therapies • Maintain staff confidentiality for personal/work issues • Communicate with staff • Suggestion box • Upgraded physical environment	• *Deep Dive* assessments to examine interfaces and key work processes in a matrix management configuration	• Communication/open forums/dialog (N=4) - *Let's Talk* sessions • Staff/office meetings (N=2) • Administrators treat staff with friendliness and respect (N=2) - role models • Intervention/coaching if behavior disrespectful • Employee satisfaction program/surveys (N=3) • Formalized written daily client schedules. • RN supervisor deals with client's complaints • Management encouragement and support (N=2) • Involved CEO • Off-site retreat on philosophy of care

Table C-10. Comments by theme and employer group related to promoting professional respect among all health professionals (Continued).

Theme	Hospitals (N=106)	Skilled Nursing Facilities (N=50)	Public Health Agencies (N=19)	Home Health Agencies (N=53)
Education	• Leadership/management training (N=8) - *Leadership Academy* - dept. supervisor meetings with education and training • Formal staff seminars related to respect (N=3) • Ethics training/program (N=2) - house-wide • Communication classes (N=3) • Customer service training (N=4) - by CEO at new employee orientation • Shared governance classes • *Code of Conduct* training • Human factors training in OR to promote communication • Orientation classes • Inservice education	• Leadership/management training (N=4) • Inservice courses (N=4) - conflict resolution - communication - culture - by DON • Consultant for in-house seminar • Scope of practice discussion	• Informational workshops for all staff	• Leadership/management education (N=4) • Customer service education (N=2) - at all levels • Education related to cultural competencies • Assertiveness training
Physician Interventions	• Meetings with MDs (N=3) - MD/RN summits to resolve issues • Work with MDs on affects of abusive behavior on quality care (N=2) • MD who is the *Nursing Advocate* handles nursing concerns regarding MDs • *Physician Well-Being Committee* • Compact between administration and MDs • Hold medical staff responsible for behavior of members • Enlisted medical staff leadership to enforce disruptive MD policy			

Table C-10. Comments by theme and employer group related to promoting professional respect among all health professionals (Continued).

Theme	Hospitals (N=106)	Skilled Nursing Facilities (N=50)	Public Health Agencies (N=19)	Home Health Agencies (N=53)
Multidisciplinary Activities	• Teambuilding/collaborative team skills (N=17) - developing team networking - organized around specific types of patients - multidisciplinary team conferences and rounds - unit-based - *Interdisciplinary Partnership Councils* for all clinical areas - use interdisciplinary approach whenever possible • Multidisciplinary improvement teams/programs (N=3) • Interdisciplinary *Professional Governance Model* • MD/RN *Joint Practice Committee* to address quality of care and work environment issues • Working on interdisciplinary and interdepartmental collaboration • *Patient Care Summit* for all patient care staff • Multidisciplinary goal sharing • More collaboration with MDs	• Team-building exercises	• Autonomous interactions with providers, other staff (N=2) • Regular interdisciplinary meetings (N=2) - for specific programs (e.g., TB management) • Address team issues and positive working relationships in multidisciplinary staff meetings	• Multidisciplinary team conferences/input (N=5) - also joint visits • All staff inservices
RN Organizational Involvement	• Unit-based action committee (N=2) - behavioral expectations and norms setting • Professional practice committee/ councils (N=2) • Nursing input into organization at all levels • Increased self-governance • Committee participation • Differentiated practice • Teamwork	• More meaningful care planning conferences around promoted principles • More committee involvement and interaction • More involvement in QI • Flexibility in decision-making • Involved in policy development	• Strategic planning (N=2) - involving total staff • Ethics committee • *Health at Work* program	• Customer service committee that addresses external and internal customers • RN-led nursing forum for problem-solving • Increased input from RNs during periods of change

Table C-10. Comments by theme and employer group related to promoting professional respect among all health professionals (Continued).

Theme	Hospitals (N=106)	Skilled Nursing Facilities (N=50)	Public Health Agencies (N=19)	Home Health Agencies (N=53)
Organizational Culture	• Hospital-wide service standards (N=14) - *Service Excellence* program - customer service expectations - embedded in performance evals - customers of each other • Zero tolerance of abusive behavior/harassment (N=3) • Expectation of respect for all (N=3) - everyone held to same standard - respect and collaboration • Core values • Mission and values orientation • Code of conduct policy • Specialty facility committed to mutual professional respect and open communication • Focus on feeling safe by promoting respect • Leadership teams • *We Can Do It* program • *Partners in Caring* program • Collegial climate	• Expectation of respect for all (N=5) - stressed during interviews, orientation - small staff, all respect each other • Core values • *LEAP* program		• Strong multidisciplinary team depending on each other for specific expertise (N=2) • Customer service program (N=2) - addresses internal and external customers - improve customer and workplace satisfaction • Standards of conduct developed and implemented • Organizational values • Orientation visits with all other disciplines recognizing contribution of each • Zero tolerance for lack of respect • All respect professional disciplinary boundaries
Recognition and Rewards	• Reward and recognition program (N=3) - professional recognition program - increased rewards for high performers • Semi-annual market review • Bonuses • Employee of the month • Special awards • Reviewing tuition reimbursement for all associates • Personal notes from managers/ administrators • Compliments	• Employee recognition (N=3) • Promote from within • Matrixed wages • Celebrate *Nursing Home Week, Health Care Week* • Competitive salaries	• Recognize contributions (N=2) • Promotion • Incentives	• Recognize contributions for special care/knowledge (N=4) - *Pride* program - *Thanks* program - *I Witness* awards • Encourage resource and preceptorship positions • Encourage specialization • Local recognition of nurses on special occasions (e.g., *Nurses Week*) • Publicize awards received (e.g., a national award)

Table C-11. Comments by theme and employer group related to overtime policies. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one method.

Theme	Hospitals (N=122)	Skilled Nursing Facilities (N=98)	Public Health Agencies (N=7)	Home Health Agencies (N=44)
Administrative Role	• Authorization/prior approval required (N=11) • Employees want overtime and are given first chance before finding outside solutions • Minimize overtime as able • Emphasis placed on monitoring to prevent excessive fatigue • No one allowed to work more than 16 hours • Look for less costly alternatives first	• Overtime monitored to avoid unnecessary/excessive overtime (N=2) • Authorization/prior approval required (N=2) - never denied • No specific policy (N=2) • Blanket approval	• Budget does not allow for much overtime - encourage comp time off • Approval on an as-needed basis	• Authorization/prior approval required (N=8) - supervisor troubleshoots prior to any overtime - supervisory staff will do field visits if necessary • Based on patient need (N=3) - overtime paid/appreciated if patient needs warrant • All support required is given • Try to avoid since affects budget/productivity
Method of Obtaining Staff	• Voluntary (N=51) - may volunteer only on days off - first-come basis - by seniority - staff routinely self-schedule for an extra fourth 12-hour shift each week • No mandatory overtime (N=10) • In-house registry decreases need for overtime (N=6) • Mandatory on occasion (N=3) - has occurred only four times in one year - for unit managers who must cover their unit if no other option available - during serious and emergency situations which have been infrequent • RN group designed overtime program • Overtime is about 4-5% of nursing hours	• Voluntary (N=4) • Ask staff first before going to agency (N=3) - more control over quality of care • No mandatory overtime • Informal limit to four 12-hr shifts • Overtime limited to extra four hours only • LVN staff typically utilized to meet overtime needs • Overtime is not allowed - DON must account for any overtime • As much as possible, schedule overtime alternate day off • Nurses self-schedule for open shifts • Mandatory on occasion (N=2) - only RN must fill in for uncovered shifts - Resident care first priority	• Overtime is rare (N=2) - only in communicable disease • Voluntary based on availability to work • Occasional weekends and evenings • RNs/PHNs flex to cover weekend and extended hour assignments	• Voluntary (N=5) - many staff like overtime • Overtime is rare (N=3) - there are many part-timers - 12-hour shifts occasionally, 16 hours are rare - occasional hospice or late admits • Nurses on-call receive overtime if must see a patient after hours • Staff share responsibilities and help each other to limit burden on one individual • Overtime used to fill open shifts • Overtime in hospice only • Most overtime is for call-backs and weekends • Staff asked to work extra days due to illness or due to an increased patient volume on a weekend • Periodic extra patient per day

Table C-11. Comments by theme and employer group related to overtime policies (Continued).

Theme	Hospitals (N=122)	Skilled Nursing Facilities (N=98)	Public Health Agencies (N=7)	Home Health Agencies (N=44)
Pay and Incentives	• Pay time-and-a-half after 8 hrs, double time after 12 hours (N=21) • Overtime incentive in addition to overtime pay (N=13) - $200 extra shift bonus - $250 extra shift bonus - cash bonus at end of extra shift - bonus incentive • Pay rate is time-and-a-half (N=5) • Paid at in-house registry rate (N=3) - up to 12 hrs and double time over 12 - time-and-a-half times plus $2/hr - also in-house registry bonus • Paid an extra $10-20/hr. • Time-and-a-half plus $16 extra per hour plus bonus for extra shifts • Overtime is paid for extra shifts scheduled with less than 24-hour notice • In-house registry receives $10 more per hour • Pay time-and-a-half rate if on-call and get called in • Pay double time for extra shifts • time-and-a-half times if called back on days or evenings, double time if called back on night shift • Fourth 12-hr day at time-and-a-half pay rate • Overtime pay after 36 hours in a week • Overtime pay after 40 hours in a week • Overtime pay after 80 hours in two weeks (8-hour shifts)	• Time-and-a-half first four hrs, double time after 12 hrs. (N=5) - Try to keep to 12 hours to avoid double time • Pay time-and-a-half after 8 hrs (N=4) • Pay per California law (N=3) • Overtime pay given the day overtime worked • Routinely pay double	• Comp time provided in exchange for overtime • Overtime pay (jail) dictated by the union	• Pay time-and-a-half after 8 hrs (N=12) • Time-and-a-half after 8 hrs in a day or 40 hrs in a week (N=3) - must be patient care -related • Pay time-and-a-half over hrs hours or over 80 hours in a pay period • Double time over 132 hrs in a pay period • Per state law • Time-and-a-half first four hrs, double time after 12 hrs. • Call-back paid at time-and-a-half and a minimum of two hours

Table C-12. Comments by theme and employer group related to options for rewarding RNs who are at the top of the pay scale. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one option.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Monetary options	• Bonus/Premium (N=49) - annual bonus - longevity bonus/premium (e.g., 15+ yrs, 20+ yrs) - recognition bonus - retention bonus - eligible for bonus - bonus for above-average/model performance - lump sum at time of evaluation - 50% of amt would have earned if not at top of scale - 1% of annual salary • Wage adjustments (N=34) - market adjustments annually/ twice yearly/frequently - annual cost-of-living increases - continue to move the top - can go over top-out range - no top - per union contract • Clinical ladder (N=20) - increased steps • Merit increases (N=3) • Longevity merit system ended when unionized (N=2) • Additional paid time off (N=2) • Periodic longevity adjustments • More differential pay • Higher employer benefits match • Longevity time off • Contractual adjustments outside of pay scale increases • No one has reached the top	• Bonus/Premium (N=14) - annual bonus - retention bonus - performance bonus • Wage adjustments (N=8) - no top of scale - continue to move the top - minimum 3% per year - annual cost-of-living increases - pay for experience - no top - per union contract • Merit increases (N=6) • Additional paid time off (N=4) • No one has reached the top (N=2) • Exceptional rate incentive • Need to do annual salary survey – hourly salary for long-term employees not competitive	• Bonus/Premium (N=3) - annual bonus - retention bonus - small % increase • Promotion to a higher level/ new job class (N=2) • Wage adjustments - when county union negotiates one • Potential for a *Director's Check* for exceptional project performance	• Bonus/Premium (N=24) - periodic bonuses - longevity bonus (e.g., 10 yrs) - percent bonus based on annual evaluation/ performance rating - lump sum - retention incentive - other incentive - developing merit bonus - $500 - small appreciation bonus • Wage adjustments (N=7) - continue to move the top/ no maximum - market analysis wage adjustments - yearly cost-of-living only - 1-5% based on evaluation - per union contract • Additional paid time off (N=5) • Additional subsidy for benefits (N=4) • Employee ownership • Clinical/career ladder (N=3) - exploring • No one at the top • Working on this issue • Not a problem

Table C-12. Comments by theme and employer group related to options for rewarding RNs who are at the top of the pay scale (Continued).

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Other Options	• None (N=14) - but working on it - organization is struggling financially • Mentorship/preceptorship opportunities (N=5) • Educational opportunities (N=4) - reimbursements for outside CEUs - offer specialty training - seminars • Multiple/incentive awards (N=4) • Non-monetary recognition (N=3) • Attend professional meeting/ conference (N=3) - all expenses paid • Schedule flexibility • Increased benefits • Retiree medical spending account • Letters of commendation	• None (N=12) - if DON wants to reward staff , must plan and pay for reward personally - no funds • Promotion (N=5) - option/training for managerial position - when position open • Scheduling leverage (N=4) - trade off days - specific off days - weekends off • Non-monetary recognition (N=2) • Increased retirement benefits • Gift certificates • Not as many as one would like • Not rewarded competitively • Not known	• None (N=13) - just more work and added responsibility - *Civil Service System* - union contract - options less competitive than 10 yrs ago • County retirement • Professional growth • Job flexibility	• Promotion (N=5) - supervisory position - other opportunities in company - to mid and upper management positions • Extra recognition (N=5) • None (N=4) • Educational opportunities (N=2) - seminars • Mentorship/preceptorship opportunities (N=2) • Very few options • Unknown

Table C-13. Comments by theme and employer group related to significant factors negatively impacting ability to retain RNs. Each comment was provided by a single respondent unless the number of respondents (N) providing similar statements is noted at the end of the comment. Multiple comments from individual respondents were included if they address more than one factor.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Compensation Competition	• Salaries (N=36) - higher salaries in competing facilities (e.g., $10/hr more) - Bay-area wages - unable to keep up with/provide higher salaries - higher salaries for younger RNs • Competitiveness among facilities (N=10) - using money to pull nurses away - hospitals "stealing" from each other - competitive giants - large teaching hospitals with endowments • Benefits (N=9) - small benefits package/rural hosp - competing large corporation with better benefits - public hospital unable to offer same level of dependent benefits as others - benefits decreasing • Extreme/outrageous/higher recruitment incentives from competitors (N=6) • Registry/traveler salaries (N=4) • Bonuses (N=3) - weekend bonuses at competing facility - no funds available for bonuses • Differentials - evening and night differentials not high enough to compete	• Salaries (N=63) - higher salaries in acute care - higher wages offered by others - government reimbursement rates too low to support adequate salaries - salary freeze/no raises due to budget cuts - maximum salary increase inadequate • Benefits (N=21) - not competitive - high cost of medical/dental insurance • Recruitment incentives (e.g., sign-on bonuses) (N=10) - in acute care due to mandated hospital ratios - from skilled nursing competitors - no budget to provide incentives • Competitiveness among facilities (N=2) - using money to pull nurses away (i.e., "buying nurses") - unfair competition due to higher reimbursement rates in acute care compared with long-term care • Owners/administrators do not understand need to provide competitive salary/benefits	• Salaries (N=15) - higher salaries in acute care - higher salaries for PHNs in surrounding counties - hospitals paying up to $600 for a 12-hr shift • Benefits (N=3) - benefit package changes have reduced benefits - county government with no allowance for special benefits for RNs • Recruitment incentives from hospitals	• Salaries (N=28) - higher salaries in acute care - government reimbursement rates too low to support adequate salaries - serve a large proportion of Medicare patients limiting income/money for salaries • Benefits (N=6) - no health benefits • Registry/traveler salaries • Highly competitive market (N=5) - acute care with better salary and benefits - insurance case management companies - competitors call RNs day and night offering more and more money and extras • Recruitment incentives from competitors (N=2)

Table C-13. Comments by theme and employer group related to significant factors negatively impacting ability to retain RNs.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Facility/Agency Characteristics	• Location of hospital (e.g., isolated, rural) (N=15) • Size of facility (N=6) - small community hospital - small rural facility - low volume and low acuity - limited growth opportunities • Lack of specialty services/little opportunity for specialties (N=4) - not full service - lack of clinical experiences (e.g., in ICU) • No problem with retention (N=4) - low turnover rates • Reputation in the community (N=4) - perceptions associated with a county hospital - corporate affiliation • Limited budget (N=3) - salary freeze • Lack of current technology (e.g., high tech equipment, information systems) (N=2) • Fiscal instability of hospital (N=2) • Academic tertiary/quaternary setting burns nurses out if not stimulated by environment • Older facility • Highly specialized hospital limits career path • Close proximity to state-run institutions • Lack of "exciting" services • Unable to expand • Change in management • Opening of new facilities nearby • Uncertain future for facility • Hospital is for sale	• Type of facility/patients (i.e., long-term care) (N=6) - negative media coverage - negative remarks about long-term care from acute care • Location (e.g., rural) (N=4) • Internal corporate problems • DHS survey process is uncomfortable since facility not seen as a resource	• Location (N=2) • Lack of job classification in public health division • California state budgets and program cuts • County system not supportive of healthcare • State prison responsibilities • No rewards/bonuses/ incentives for long-term employees • Micromanagement of health department • Most suggestions for recruitment and retention are not considered • Frustration with bureaucracy - pay for longevity rather than performance	• Location (N=5) - of patient's home - geographic area • Poor management/leadership • A lot of changes

Table C-13. Comments by theme and employer group related to significant factors negatively impacting ability to retain RNs.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Family/Living Issues	• Cost of living/housing (N=33) - lack of prospect for home ownership - relocate out-of-state to find affordable housing • Spouse/significant others have difficulty finding work (N=4) • Cost of relocation (N=2) • Distance to work (N=2) - move closer to home • Family relocation (N=2) - military families	• Cost of living/housing (N=5) • Family relocation	• Cost of living/housing (N=2) • Family relocation - loss of spouses' job	• Cost of living/housing (N=4) • Family relocation • Spouse/significant others have difficulty finding work/lost jobs • Part-time nurses less likely to work as economy picks up
Interpersonal Relationships	• Attitudes toward newly hired RNs (N=3) - attitudes of training staff - other RNs "eating their young" - new hires who are not a "fit" are not welcomed by current RNs • Physician behavior (N=3) • Communication deficits in new hires who talk among themselves and ostracize current employees • Employee-employee conflict	• Poor relationships with supervisor • Lack of respect from other Departments		
Opportunities for RNs	• Opportunities with day shifts and no weekends (N=3) - outpatient settings - work with physicians • Larger facilities (N=4) - experiences available at a larger facility - more opportunity for advanced practice education and advancement in a larger facility - accessible if willing to commute • RNs leaving clinical positions • Workforce mobility in general (N=2)	• Lack of advancement opportunities (N=2)	• Better hours at schools • Few opportunities for advancement • Lack of training for advancement	• Few training opportunities • Other agencies that offer smaller geographic areas for home visits/driving and no on-call

Table C-13. Comments by theme and employer group related to significant factors negatively impacting ability to retain RNs.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
RN Characteristics	• Engagement/commitment (N=6) - easily move to another facility for the sign-on bonus - leave after bonus timeframe met - want to move after 1-2 years to see what else is available - shopping/moving around for best package - lack of commitment - not able to commit to rural nursing • Aging workforce (N=3) • Personal issues/uncontrollable factors (N=2) • Desire to travel	• Burnout from physically and emotionally draining work (N=4) • Interest in trying acute care now that positions are available (N=3) • Expectations/salary demands excessive (N=2) • Aging workforce/retirement • Go to home health or administration to advance • RNs who worked two jobs give up the one with fewer benefits • Lack of experience in long-term care • Inadequate knowledge base • Lack of accountability since able to find another job • Recruit older RNs who have "had it" with hospitals	• Aging workforce/retirement	• Competency of applicants (N=4) - "not what they used to be" - hard to find a qualified applicant • Job satisfaction (N=2) - home care not for everyone • Home health requires high levels of clinical expertise, time management skills and independent practice (N=2) - hard for average nurse • Personal issues/ uncontrollable factors (N=3) • Engagement/commitment (N=2) - lack of commitment - overextend with work commitments to other employers • Aging workforce
Scheduling	• Shifts (N=7) - not enough permanent day shifts - vacancies are on PM and night shifts - rotating to night shift - night and weekend shifts particularly difficult to fill - shifts available are not wanted by potential recruits - floating • Balancing needs of per diem staff and hospital requirements • Seniority issues - schedule inflexibility - vacation scheduling • Unable to provide flexible scheduling	• Shifts - staff do not want to work weekends and odd shifts - limited shift availability	• Grant funding does not always allow desired work schedule	• Must take on-call duty (N=2) • Weekends • Scheduling demands

Table C-13. Comments by theme and employer group related to significant factors negatively impacting ability to retain RNs.

Theme	Hospitals (N=177)	Skilled Nursing Facilities (N=155)	Public Health Agencies (N=39)	Home Health Agencies (N=119)
Staffing/Workload	• Shortage of RNs (N=14) - simply not enough RNs to meet demand in community - lack of experienced RNs - lack of qualified candidates for specific job requirements - insufficient number of nursing programs/graduates in the state • Workload (N=10) - maintaining consistent - fluctuating demand/census - no layoff policies • Nurse-to-patient ratios (N=3) - decreased nursing assistant and unit coordinator help since ratios instituted • Training for specialty areas (N=2) • Floating to specialty areas • LVNs in the skill mix • Staffing in general	• Shortage of RNs (N=10) - lack of RNs able to function in skilled nursing facility - limited number want LTC - acute care hiring all RNs to meet ratios - H-1B visas discontinued - insufficient number of nursing programs/graduates • Workload (N=12) - high nurse-to-patient ratios - staffing levels in LTC - inability to structure day to complete work satisfactorily - too much job responsibility • Paper compliance (N=4) • Increased acuity of patients • Budget limits hiring of RNs who function at higher levels • Constant staffing crisis	• Shortage of RNs (N=2) - non-nursing public health directors use expense and difficulty in obtaining RNs as excuse not to hire • PHNs must be able to function in a variety of programs (N=3) - categorical funding means many duties for one job - nature of the work	• Paper compliance (e.g., Oasis) (N=24) - unreasonable - tedious • Workload (N=7) - stressful - difficult patients - hard work - hospice is draining - available RN cases not always exciting • Travel/long distances to clients (N=7) - gas prices • Shortage of RNs (N=5) - increased workload • Productivity expectations (N=2) • Too much overtime
Support for RNs	• Need to mentor new nurses (N=3) - lack of qualified preceptors to support novice/new employees - 1ack of support from preceptors/ educators/mentors • Work environment (N=4) - stressful workplace - organization of the work - work culture - environment not supportive • Lack of educational opportunities • No career ladder	• Work environment - uncomfortable work atmosphere	• Lack of centralized orientation to give optimal grounding in job duties • Lack of formal mentorship program	• Need to mentor new nurses - problem maintaining administrative RNs to supervise/train/orient others
Union Activity	• Drawn out contract negotiations • Contentious union issues • Presence of union • May lose some of our best who fear working under the union			• Union activities

Appendix D
Best Practices

List D-1. "Best practices" listed by respondents from hospitals related to retention of RNs. Each "best practice" was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents were included if they address more than one practice.

Benefits and Incentives

- Competitive salaries (N=3)
  - increased salaries to meet those of another facility
- Longevity bonus (N=2)
- Retention bonuses (N=2)
  - finder's fee to current employee after new employee working 90 days
- Greatly enhanced benefits to the RN retirement program
- Health insurance for dependents
- Incentive bonus
- Bonus for extra work
- Improved financial incentives
- Paid vacation and holidays (i.e., 36 per year)
- Bonus for preceptors
- Guaranteed full-time hours with no call-off for low census
- RNs able to work in other departments when flexible down staffing is required
- Substantial referral bonus is paid out in 18 months assuring mentoring, welcoming of new hire
- Unit reward after new hire has been on unit for one year

Career Trajectory

- Career/clinical ladder (N=6)
  - clinical levels program supports advancement on clinical or management track with promotion and economic reward based on completion of additional education
  - added another staff nurse level
- Developed career paths for nurse preceptor, mentor, and clinical educator

Interdisciplinary Culture

- Collaborative practice
- Corporate-wide best practice committees
- Monthly interdisciplinary inservice education programs
- Interpractice partnership and collegiality

Leadership

- Good relationship between staff and managers/management team (N=5)
  - labor/management partnership
- Formal leadership training (e.g., for frontline managers, all RNs, Advisory Board) (N=4)
- Unit management (N=4)
  - managers have only one unit
  - minimal turnover in two specialty units with great leadership emphasizing excellence in quality and customer service
  - strong unit managers
  - unit based managers and clinical nurse specialists to provide support on all shifts

List D-1 (Continued):

Leadership (Continued)

- Listening to concerns and following up in a timely manner (e.g., town hall meetings, administrative forums) (N=4)
- Open-door policy (N=4)
- Rounding/visibility (N=3)
- *Magnet Hospital* program (N=2)
- Administration and managers that mutually respect and support each others' values
- Leadership teams
- Charge nurse development
- Leadership that really cares about staff
- Hired a nurse recruiter to match new hires with organizational needs
- New manager introducing many staff-friendly policies
- Actively working on team-building with management support
- Availability of nursing and administration leadership to line staff
- Better communication with management
- Strong, experienced nursing leadership
- Excellent managers
- Respect for administration
- Leadership philosophy based on *Total Quality Management*
- Nurse executive luncheon with new staff
- All staff able to attend a quarterly luncheon or dinner with administrative team
- Focus on patient safety goals
- Providing staff with information on financial restrictions of the hospital because of its unique characteristics
- Redesigned management team
- Front line managers trained to be chief retention officers

Nursing Education

- Relationships with schools of nursing (N=2)
  - nursing advisory board meets with CNO monthly related to students/ recruitment
- Recruiting students from clinical rotations/student worker program

Nursing Practice

- Excellence/pride in work (N=4)
  - staff enjoy telling about others how they serve the public here
  - campaign related to honoring the call to nursing
- Instituted a lift team (N=2)
- Technological support (N=2)
  - decreased RN response time by telecommunicationg IV pump alarm to nurses' beeper
  - implementation of bedside barcode technology for medication administration
- Cross-training of specialty unit nurses has increased camaraderie as well as promoting a sense of teamwork and valuing among nurses
- Developed a new nursing model
- Development of care teams in med-surg that focus on special care issues (e.g., wound care)
- Focus on research, primary nursing
- New family-centered patient care unit based on compassionate care and respect for patients/staff
- New patient care manual referencing all policies
- Participation in national transformational care project t allows staff to evaluate ideas in a rapid cycle change format
- Unit-level involvement with national collaboratives for best practices

List D-1 (Continued):

Organizational Culture

- Team/family spirit (N=7)
  - allowed to laugh and enjoy work
  - caring colleagues
  - camaraderie
  - family-oriented climate where everyone is valued
- Pleasant environment/culture (N=5)
  - encouraging and nurturing environment
  - professional, autonomous, friendly nursing practice environment with 90% RN staff mix
  - staff stay because of the culture and people they work with in this beautiful, clean facility in nice location which serves the community well with excellent care
- Teamwork (N=3)
  - smaller facility with team approach and community-based philosophy
- Faith-based mission (N=2)
- Collaboration and partnering to meet organizational goals
- Excellent internal as well as external customer service program
- Dramatic results from a new culture of being positive and respectful to everyone
- Empowerment
- Love
- Organizational emphasis on a learning environment facilitated recruitment and subsequent decrease in travelers which was the major staff dissatisfier impacting retention
- Valuing the RN as the center of care

Recognition

- Recognition program (i.e., rich, formal, varied) (N=4)
  - recognition of individuals in-house and in the community
- Special awards programs (e.g., hero, extra mile)
- We make sure our great nurses hear it from us

RN Organizational Involvement

- Self/shared governance (N=4)
  - in one unit where staff willing to take ownership, greatest retention rate
- Involvement of RNs on committees (N=2)
- Staff empowered to resolve clinical or workflow issues through participation in special councils
- Include staff nurses as teachers in continuing education classes
- Involving RNs as much as possible at every level
  - invited to be part of task forces related to specific interest of RN
- Professional practice committee
- Involvement in organizational initiatives
- Off-site retreat for RN role development
- Recruitment and retention committee with representation from new and experienced staff
- Staff decision to be excellent teachers/role models for students and new graduates
- Staff-driven initiatives
- Unit-based practice/quality committees (N=3)
- Unit-based employee satisfaction teams
- Unit staff hired through peer review process/involvement of current staff (N=2)

List D-1 (Continued):

Staffing/Scheduling

- Self-scheduling (N=2)
- A working healthy program in a subacute unit resulted in no use of registry for over a year and decreased turnover
- Behavioral interviewing to fit employee with mission
- Floating clusters
- Good ratios with some exceeding recommendations even prior to institution of mandatory ratios
- Hired employee support coordinator for licensed employees
  - specific attention for 90 days to integrate new hires into organization with follow-up for one year
  - has reduced turnover
- In-house registry with higher rate of pay
- Continued use of CNAs with ratios

Support for Professional Growth

- New graduate/trainee program (N=13)
  - expanded/extensive
  - preceptored new grad program
  - divisional staff developers available to assist new grads
  - six-month residency program followed by opportunity for RN to select a mentor for another six months to facilitate transition into practice
  - recruited RNs given one year of support/training (required to remain two years after training)
  - 12-week new graduate program
- Specialty unit transition/training programs (N=7)
  - cross-training available
- Scholarships/tuition reimbursement for continuing formal education (N=5)
  - includes LVN to RN program
- Preceptor/mentor preparation/program (N=4)
  - with follow-up
- Advanced Certification Encouragement and Support (N=3)
  - classes, travel and reimburse renewal costs
  - provide speaker for CCRN review classes for ICU followed by support study groups
- Nurse educators (N=3)
  - large staff development department
  - unit-based educators
- Online continuing education (N=3)
- Onsite BSN/MSN programs (N=3)
  - Partnered with a local college to bring the RN-to-BSN program into the facility
  - RNs scheduled so can attend teleconferenced courses from statewide RN-to-BSN program
- Encourage and facilitate professional growth/education (N=2)
- Continuing/inservice education (N=2)
  - more inservice education
  - luncheon inservices which allow RNs to obtain 30 CEUs in two years on-site at no cost
- Nursing grand rounds (N=2)
  - monthly
- Critical thinking education
- Paid off-site training for specific skills (e.g., emergency delivery, telemetry)
- Professional nursing institute has supported career development and growth for nursing staff
- Training management and staff for shared governance
- Environment rich with opportunities to learn and be valued
- Visiting professor series
- Ongoing educational offerings in the county

List D-2. "Best practices" listed by respondents from skilled nursing facilities related to retention of RNs. Each "best practice" was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents were included if they address more than one practice.

Benefits and Incentives

- Good/competitive salary and benefits (N=3)
- Scholarship program (N=3)
  - assistance for LVN to RN
- Good benefits package (N=2)
- Free meals (N=2)
- Health insurance benefits (N=2)
  - for some nurses
  - 75% of health care insurance costs
- Performance reviews (N=2)
  - conducted frequently with reassessment of pay rate
  - merit compensation based on evaluation
- Yearly raises
- Increased salaries
- creased time off
- Pay for uniforms
- Large Christmas bonus
- Salary based on years of experience

Interdisciplinary Culture

- Interdepartmental support/communication (N=2)
- Good interpersonal relationships among disciplines
- Staff, MDs welcome to call RNs by first name
- Daily interdisciplinary team meetings about resident care decisions
  - RN input valued, respected

Leadership

- Good working relationship/camaraderie between management and staff (N=7)
  - open communication
  - enjoy working with staff and being flexible with requests
  - do not mind helping out
- Open door policy and creative listening
- RN as valued leader of the team
- Restructured flow of information from administrator and CEO to RN staff
- Fair and equitable treatment of staff
- Provide individualized assistance
- Regular nursing department meetings
- Foreign recruitment
- Changing work conditions/team attitudes through team building, autonomy and customer service standards
- Clinical support for staff by nursing management if workload overwhelming

Nursing Practice

- Autonomy (N=4)
  - RNs allowed to utilize maximum scope of practice capability
- Excellent quality of care (N=3)
  - no physical restraints, zero in-house acquired pressure sores
- Pain management

List D-2 (Continued):

Organizational Culture

- Working environment (N=22)
  - pleasant, friendly
  - stable
  - family-oriented
  - good place to be
  - fun activities
  - support each other
  - RNs feel comfortable so they stay
- Respect/dignity (N=8)
- Teamwork (N=7)
  - team support from the top down
  - family/team spirit
  - comes first after residents
  - pitch in and help
- Strong employee core values
- Strong safety program with work safety incentives
- Religious nature of facility and philosophy of care
- Commitment to mission to care for the elderly
- Facility respected in the community (N=2)
- Quality facility that is clean and well-maintained
- Small facility (N=2)
- Staff longevity (N=4)

Recognition

- Positive recognition (N=8)
  - make staff feel they are very important to the organization/reinforce need for staff
  - on-the-spot recognition/praise
- Award presented monthly during staff meeting to an employee going above expectation and includes a small gift from management
- Each year, residents recognize all the staff with a monetary gift

RN Organizational Involvement

- Nursing staff involved in decision-making related to nursing care (N=2)
- Involvement at Board level where policy decisions are made

Staffing/Scheduling

- Flexible scheduling (N=8)
- Work with employees to accommodate requested days off (N=3)
- Set schedules (N=2)
  - unit and shift consistency
- 12-hour shifts
- RNs specifically assigned to MDS
- RNs who do weekend coverage
- Self-scheduling

Support for Professional Growth

- Continuing education for professional growth/development (N=5)
- Orientation (N=3)
  - comprehensive, no set number of days, continuing until new hire comfortable without support
  - preceptorship
- Computer education and support to learn computer system

List D-3. "Best practices" listed by respondents from public health agencies related to retention of RNs. Each "best practice" was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents were included if they address more than one practice.

Benefits and Incentives

- Extra pay for ANCC certifications (up to 5)

Interdisciplinary Culture

- Presentation of the role of PHNs and public health clinics in meeting regional strategic planning goals

Leadership

- Director of Public Health is pro-nursing and works to retain RNs
- Management listens to employees
- Mutual agreement on issues by consensus
- Working for *Magnet* status for PHNs/public health

Nursing Practice

- Autonomy (N=3)
- Reduced the responsibilities of nurses by decreasing services offered
- Ability to be a patient advocate
- Role diversity and flexibility

Organizational Culture

- Interpersonal respect
- Organizational climate
- Monthly nurse staff meeting with potluck
- Congenial workplace (N=2)

RN Organizational Involvement

- Input into every aspect of the organization
- Participate in program development
- Make changes in the way they work
- Working conditions are an advantage
- Re-establish professional role of the PHN in the public health system and utilize skill base at the leadership level
- All committees have nursing representation

Staffing/Scheduling

- Assigning work with community groups along with caseload assignments

Support for Professional Growth

- Encourage, support and give recognition for continuing education and learning (N=2)
- Training (N=3)
  - for new assessments (e.g., NCAST)
  - in communicable disease investigation
  - in home visiting techniques

List D-4. "Best practices" listed by respondents from home health agencies related to retention of RNs. Each "best practice" was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents were included if they address more than one practice.

Benefits and Incentives

- Competitive rates of pay (N=3)
  - equity adjustment
  - increased dollars
- Retention incentives (N=2)
  - bonus and pension
- 401K and longevity bonus

Career Trajectory

- Actively encouraged toward a promotion track

Interdisciplinary Culture

- Collaborative clinical meetings to provide feedback on outcomes when a specific project implemented for a problem
- Excellent communications among multidisciplinary team members

Leadership

- Supportive administrative/supervisory staff (N=3)
- Open door policy with nursing leadership
- Monthly staff meetings to obtain RN opinions, questions and concerns related to job responsibilities
- Solid management team
- Improved agency structure
- New office manager
- New corporate system
- Corporate support
- Evaluating *FISH* philosophy to make work more enjoyable
- Experienced, competent supervisor
- Management style
- Constant feedback and informative mailings
- Paid facilitator four times each year to provide staff support
- Treat RNs like customers
- Do everything possible to make relationships positive
- Rotated weekly supervising visit with staff and assigned patients
- Personalized attention
- Organized information
- Entire organization involved in business planning with achievement of goals and strategies outlined in the plan tied to job descriptions
- Seeking *Magnet* status

Nursing Practice

- Autonomy, independence, professionalism and flexibility in practice (N=10)
  - encourage independent thinking
  - with excellent management support
- Quality of care (N=2)
  - raised the quality
- Perceived value in nursing practice role

List D-4 (Continued):

Organizational Culture

- Good working/interpersonal relationships (N=6)
  - treat each other with respect/value each other
- Small, team-oriented agency (N=3)
- Sense of ownership (N=2)
  - embrace organizational mission
- Quality employees at all levels
- Low stress environment
- Agency reputation
- Good communication
- Cohesive, team approach
- Supportive, empowering environment
- Nurturing, friendly environment that feels like family; celebrate events (e.g., birthdays) and do outside activities together

Recognition

- Appreciation day for RNs
- Frequent employer appreciation activities
- Symposium on excellence in rural nursing celebrated the rural nurse as a specialist and increased morale for a long time
- *Seeds of Excellence* program highlights individuals for their professionalism/nursing excellence
- Regional and corporate acknowledgement for excellent quality of care to patients
- Monthly recognition in staff meetings for outstanding performance (i.e., with certificates, pens)
- Recognition for any employee who goes above and beyond expectations (e.g., taking extra call, work on day off)
- Recognition for contributions to performance improvement projects

RN Organizational Involvement

- RNs have input into proposed workflow changes (N=3)
  - opinions are respected
- Recruitment and retention committee responsible for satisfaction surveys
- Increased participation in decision-making related to policies and procedures

Staffing/Scheduling

- Work never canceled due to decreased census
- Flexibility in scheduling (N=2)
- Flexible with time off for child care allowing nurse to return to work when able
- Reasonable caseloads
- Strict screening process

Support for Professional Growth

- Continuing education (e.g., monthly, with CEUs, per staff request) (N=5)
- Orientation program (N=5)
  - full FTE devoted to orientation
  - competency-based/individualized
  - three-month orientation without productivity standards
  - 60-day clinical orientation
  - mentorship program designed by the nurses/one-to-one mentoring
- Preceptor program (N=2)
  - has reduced turnover during first year of employment
- Support for special educational interests (e.g., becoming a diabetes educator) (N=2)
- University access on intranet site so that staff can log in and take courses

Appendix E
Additional Comments

List E-1. Additional comments listed by respondents from hospitals related to recruitment and retention of RNs. Each comment is from a single respondent. Multiple comments from individual respondents may be included.

Administration

- Complete administrative team replacement recently
- Implementing a new customer satisfaction program focusing on positive relationships among all staff and with more staff recognition
- Looking at recruitment, recognition, and positive relationships with all staff members
- Recently hired a "retention officer" who will focus only on employee retention
- Corporate survey of retention opportunities recently completed resulting in a guide for retention "best practices"
- Leadership needs to be very visible, willing to pitch in when needed, available to listen and support, and show respect by example

Bureaucratic Inhibition

- It is very difficult to make changes to promote retention in a facility under civil service rules
- California's lower reimbursement for healthcare, higher cost of living, higher RN salaries, and nurse-to-patient ratios make it very difficult to "stay in the black"
- Transportation is an issue with long commute times and high gasoline prices—need mass transit

Nursing Education

- Built relationships with ADN program faculty and students
- Greatly improved our ability to recruit when we provided a more positive environment for the nursing students
- Partnerships with local nursing schools are a key to success In the process of developing a school coordinator/liaison position to help develop and maintain school partnerships
- What worked was creating a student friendly environment and a strong vision for nursing and patient care
- One excellent nursing program lead students to tertiary care facilities Perhaps they do not realize the value of a smaller facility for growth in a nursing career
- Have RN and LVN students in the hospital
- Hire student nurses which gives them broad clinical experiences and ease of transition upon graduation and licensure
- Not enough schools or educators to meet demand
- Have LVNs who want to be RNs but they must leave the area since there is no school here Further, since not rated as medically underserved, cannot get any help, either
- Work hard to "grow our own" by supporting an in-house CNA program, LVN program, and a program to assist LVNs to continue education toward the RN

Nursing Practice

- Nurse-to-patient ratios required a shift from a team to a "total care" nursing model which reduced job satisfaction, at least temporarily, although there has not been significant turnover as a result
- Difficult to get foreign-born RNs from some cultures to take charge and communicate with physicians

List E-1 (Continued):

Organizational Culture

- Small community in which we celebrate with and console each other
- Attribute retention to a very cohesive workforce, interdisciplinary team relationships, and rewards of working with a specialty population
- Nurses are given challenging work, recognized for their performance, as well as feel engaged and involved in the hospital --they also like and support their immediate manager/supervisor and senior management
- Promotion of the mission statement
- The environment is a friendly family setting
- Offer flexible self-scheduling and self-assignment in most units
- An excellent unit-based culture is what makes the greatest difference
- Long-tenure staff willing to stay with the hospital until a planned move takes place
- Worried about the affect of the coming union election
- Union election coming next year

Recruitment Sources and Actions

- About 65% of RNs who seek employment are referrals from RNs who think highly enough of their work environment to encourage friends to apply
- Best recruiters are the staff
- Recently hired a full-time nurse recruiter
- Would prefer a nurse recruiter rather than a non-nurse recruiter currently in the role
- Do immediate on-site interviews
- Use multiple advertising approaches to attract candidates (eg, intranet, internet, newspaper, NurseWeek, Minority Nurse)
- Difficult to find the right advertising medium that produces results
- Recruitment can be difficult as we offer no hiring or relocation bonuses and do not offer tuition reimbursement
- Have offered positions to a cohort of 30 BSN-prepared Filipino nurses to eliminate agency and traveler costs
- Meeting with an international recruitment firm to discuss options
- About 80% of the RNs were recruited from outside the country
- International recruitment has helped fill some vacancies
- Branching out to other states to recruit better-qualified candidates

Remuneration and Recognition

- Hospitals are going to need to pay higher wages of in-patient nursing staff in the future
- Have both sign-on and retention bonuses
- Have sign-on, retention, and some relocation bonuses
- Employees have additional benefits advantages after fifteen years of service
- Rewarding current employees with a recruiting bonus has been moderately effective
- Full benefits for staff working three 12-hour shifts with no requirement to work over 36 hours in a week
- Offer three retirement programs, all of which are available to benefited staff and one with an employer match of 3:1
- Tuition reimbursement even for per diem staff members
- It is difficult to recruit to a rural area and for a rural hospital to keep pace with salaries
- Choose not to offer sign-on bonuses and offer professional growth opportunities instead
- Provide employee awards and recognition

List E-1 (Continued):

RN Shortage

- Not enough RNs
- Everyone is chasing the same nurses; there are just too few worldwide
- Shortage of new grads and experienced nurses
- Cost of living, the nursing shortage, and the competitive market strain retention and recruitment

Staff Organizational Involvement

- Maintain an active retention and recruitment committee
- Work hard to include RNs in decision-making to make them feel like part of the team
- Staff RNs help in the new hire process
- Ask staff for input into decisions that will impact their work

Support for Professional Growth

- Use orientation and educational process as selling points
- Continually provide staff with new programs based on their stated needs

Recruitment and Retention Not An Issue

- Recruitment and retention are not significant issues in our facility
- Had zero turnover in the first quarter of this year
- Currently have less than a one percent vacancy rate
- Have less than ten percent turnover

List E-2. Additional comments listed by respondents from skilled nursing facilities related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Acute Care Competition

- Retention issues revolve around the large stay-on bonuses given by the acute care hospital
- Increased need for RNs in acute care settings is drawing RNs from long-term care even if they are happy there
- Use LVNs rather than RNs because of increased pay for RNs in acute care or registry
- RNs prefer acute care where there is more money and 12-hour shifts

Administration

- Administration does not seem to understand the need to decrease workload and increase salary and benefits for RNs
- Poor ownership practices
- Evaluating effectiveness/usefulness of agencies—poor quality, expensive

Bureaucratic Inhibition

- We need more foreign recruitment and the INS should allow/facilitate it
- Slow immigration paperwork

Nursing Education

- Need to increase capacity in nursing schools
- Nurses need training not to "awfulize"

Nursing Practice

- There seems to be an absence of accountability in practice with those who are accountable bearing the load of those who are not For example, following counseling and conversations about restructuring time, have had to fire several nurses recently because they did not complete treatments or pass medications as ordered
- Would prefer LVNs who seem to be more patient-oriented than RNs seen recently
- RNs are only interested in management They are needed for charge nurse positions for their leadership and assessment skills
- If skilled nursing facilities are compliant with OBRA, nurses do not have the luxury of restraints, medications, catheters and frequent physician visits available to acute care nurses

Organizational Culture

- Provide a good working environment in which staff are happy (N=2)
- Nurses have to be treated with respect and given the training they need to do the job
- Desirable skilled nursing facility (safe, beautiful environment, excellent surveys, no registry use) but generally get a very poor response when recruiting for licensed nurses
- We have a reputation in the community of treating staff with respect
- Offer a place with scheduling flexibility so nurses can manage their career and their family
- Most staff stay because of the close family environment
- Good interpersonal relationships among staff
- Good reputation
- Small facility that does not appear safe at night
- Nursing leadership communicates with staff as colleagues rather than as a superior
- We do not work short of staff.

List E-2 (Continued):

Recruitment Sources and Actions

- Sponsor foreign nurses (N=5)
  - in exchange for a service commitment
  - changed from a one-year to a three-year commitment for overseas recruits
- Recruit from among many ethnic groups promoting the fact that the facility is multicultural and that everybody is treated equally.
- Recruitment is ongoing even if all positions are filled
- Staff are begging friends to come to work.
- Corporate foreign nurse recruiter goes to the Philippines regularly
- Flexibility in scheduling is communicated to peers who are recruited to facility

Remuneration and Recognition

- Better pay for experienced RNs, including educational compensation
- Financial support for RNs who want to go on for further education
- Offer a per diem rate
- Referral bonuses
- Pay well and offer good benefits
- Offer sign-on bonus, staff recruitment bonus, good benefits, and a higher differential salary to non-benefited employees
- We stay competitive in terms of wages
- This is the first year of difficulty and salary is a major issue
- Decreased census affects pay rates and benefits
- Salaries in skilled nursing facilities should not differ from acute care settings--there is a high acuity level in the skilled facilities

RN Shortage

- Availability is an issue
- Shortage of applicants
- Too few nurses willing to work in long term care when they have many other options (e.g., physician's office, auditing insurance records) which allows them to avoid a 24-hour facility.
- RNs are scarce so have hired some LVNs who are working well with the team
- The shortage increased RN wages so now small long-term care facilities cannot compete
- Hiring RNs is like pulling teeth and is a never ending problem

Support for Professional Growth

- Long-term retention due to career ladder and team-building

Recruitment and Retention Not An Issue

- No problems with recruitment and retention (N=2)
- Staff stable for 7 years

List E-3. Additional comments listed by respondents from public health agencies related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Administration

- Need to re-establish the professional role of the PHN in the public health system and utilize the skill base at the leadership level

Nursing Practice

- Autonomy in practice.
- The facility is so small that nurses must wear many hats making it difficult to employ someone right out of school without experience
- Lack of commitment or interest from nurses makes retention harder
- Require bilingual staff with specific types of experience: comprehensive case management for multi-problem, multilingual, multicultural clients; home visiting; public health issues such as communicable diseases; and program direction.

Organizational Culture

- Nurses with children appreciate the flexible schedule
- Some of our staff "burned out" in acute care and love the more relaxed pace and prevention aspects of public health
- Many staff members are in public health because of the regular week-day schedule which makes it easier to manage child care and family obligations
- Have applicants because of the interesting work, desirable schedule, and many opportunities for professional growth

Recruitment Sources and Actions

- Hard to recruit, less difficult to retain (N=3)
- Best recruitment occurs by word-of-mouth from PHNs who left the hospital or home health and have experienced the satisfaction of not being driven by quotas and payment sources
- Use of the *Nurse Intern* staff recruitment position
- Participate in the *National Nurses Student Loan* program

Remuneration and Recognition

- Difficult to recruit due to salary constraints.
- For the last two years, state and county budget constraints have made pay increases with the private sector impossible and other incentives for such as additional pay for advanced degrees and certifications are also unlikely

Staff Organizational Involvement

- PHNs stay because they know their opinion matters

Staffing

- Need staffing standards in public health to meet the needs of the population to assure a healthy community

List E-4. Additional comments listed by respondents from home health agencies related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Acute Care Competition

- Recruiters from other agencies (e.g., acute care) call RNs on the job to recruit them elsewhere, offering large sign-on bonuses; no accountability if the RN quits
- Hard to compete with incentives in acute care

Administration

- Upper management recognizes the need to raise compensation levels and is seeking input from other levels
- Recruitment and retention funds are very limited
- Work diligently to create a supportive culture; managers are very approachable

Bureaucratic Inhibition

- Home care is no longer a draw for nurses leaving acute care due to the daunting documentation requirements
- Medicare, over the last few years, has treated RNs as criminals, labeling actions as "fraud" when they were not. Many of the RNs quit the profession
- Third party payors do not cover the cost of doing business in rural California let alone provide the ability to provide incentives to nursing staff to work harder performing non-nursing functions
- Nurses select homecare because of the lighter workload but it is hard to sustain the nursing workforce because of the level of OASIS documentation required
- Need to increase MediCal and Medicare rates to keep rural institutions financially stable

Nursing Education

- Do not lower standards for nursing graduates or the length of the Board exam
- Need weekend graduate programs similar to the Executive MBA programs

Nursing Practice

- Clearly communicate that clinical excellence is the goal
- Recruitment is hard because there seems to be little information out about the role of the nurse in home care--once they come, nurses tend to be very happy, find their work rewarding, and want to stay
- It is difficult to find nurses who are able to perform independently as well as keep up with the high demand of patient care and paperwork required
- Have a holistic patient care model encompassing body, mind, and spirit that appeals to nurses
- Poor quality of applicants looking for high pay for little work, poor documentation skills, lack team effort and have attendance problems
- Some RNs avoid home health because they misunderstand it

Organizational Culture

- Nurses want to work for us because they hear about our excellent care, high degree of organization, top salaries, interest in performance improvement, and willingness to allow flexible scheduling
- Flexibility in response to time-off requests, including a leave of absence even if only for a few days
- RNs stay longer because of the company's good reputation and stability
- RNs stay because they enjoy working in the supportive, non-punitive environment, with scheduling flexibility and opportunities for continuing education

List E-4 (Continued):

Recruitment Sources and Actions

- Home health attracts RNs from skilled nursing facilities because they like the freedom of being out in the field

Remuneration and Recognition

- Low pay due to cutbacks in Medicare for home care (90% of patients are Medicare)
- Will be in a better position to recruit and retain nurses when the compensation levels are raised
- Offer a social security alternative and retirement plan along with lower health insurance rates than surrounding agencies
- Frequent appreciation events such as providing breakfast or lunch

RN Shortage

- Recruitment is difficult with the RN shortages (N=2)
- Shortages of PT, OT and Speech Therapists as bad as shortage of RNs
- Lack of an employee base hits rural areas especially hard

Staff Organizational Involvement

- Nurse-run efficiency task force

Support for Professional Growth

- Totally revised our general and clinical orientation
- Need a nurse internship program for new graduates and nurses new to hospice and palliative care
- Have evening classes for ADN nurses wanting to obtain the BSN

Recruitment and Retention Not An Issue

- Long-term employment of several RNs (N=2)
- Rural community lucky to have staff longevity
- Fortunate to have experienced professional nurses in a strong agency with a good reputation

Appendix F
Recommendations

List F-1. Recommendations listed by respondents from hospitals related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Boards of Nursing/Licensure

- Speed up process for out-of-state individuals to obtain California licensure
- Board of Registered Nursing report gives a false sense of the number of RNs in the state because of the inclusion of travelers and retirees who keep their licenses
- Control granting of LVN licenses to CNAs who receive essentially no didactic preparation
- Establish BSN entry into practice (N=2)
  - even though there is a shortage
  - to better establish the profession and the mindset needed to provide care in the current environment as well as maintain appropriate salaries and parity with other health professionals

Compensation

- Fund rural hospitals to meet the new pay rates
- Being held hostage by registries and temporary agencies demanding premium time payment (i.e., they schedule, then call and cancel unless they receive double time)

Hiring Issues

- It is scary to hire a nurse since facilities cannot share information about previous negative behaviors and there is no central database where information can be obtained.

Nursing Education

- Fund nursing schools to increase enrollments/graduates (N=25)
  - support for both ADN and BSN programs
  - nursing schools should not be turning away qualified candidates
  - this is critical
  - partner with schools to increase slots
  - need federally funded grants
- Need more nursing faculty positions (N=6)
  - pay must be increased so faculty can realize financial as well as professional gain
  - state should examine compensation for nursing faculty since it is currently way below bedside that of bedside nurses
- Increase the number of nursing programs (N=7)
  - most programs are impacted with long waiting lists
- Need more BSN programs/capacity (N=3)
  - need to graduate higher caliber of nurses with critical thinking skills
- Make school/prerequisites easier (N=2)
- Select students by qualifications, not by lottery (N=2)
- Increase education in team leading, critical thinking, delegation and supervision of subordinate staff (N=2)
- Expand the community college system to allow immediate post-high school admission
- Provide funding for non-RN hospital employees to transition into RN programs
- Decrease out-of-state tuition to increase the number of students

List F-1 (Continued):

Nursing Education (Continued)

- Fund nursing re-entry programs
- Develop shared faculty between service and academia
- Better preparation of RN new grads for work reality
- Increase prerequisite courses
- Improve student's clinical knowledge
- State should work to make entrance requirements for California nursing programs consistent and easily transferable
- Need grant funding to support residency programs
- There was significant legislative activity to enact nursing ratios but minimal legislative activity or funding addressing the severe shortage of nursing instructors and schools

Organizational Culture

- Change the organizational culture to reduce physical demands
- RNs should always be asked to do something rather than ordered to do it
- Physician verbal abuse to staff continues to be a problem
- Elected rural hospital Board members can be a stress to nursing management

Overseas Recruitment

- We will continue to import nurses from other countries but to do this ethically, the program should focus on technological transfer with nurses coming to the US on working visas rather than immigrant visas and returning home after a maximum of five years to participate in the education of future nurses in their home countries—those remaining after five years should be mandated to work in medically underserved areas, like the MD J-1 visa.

Professional Growth/Support

- More focus on educational needs of RNs with more than five years of experience
- More leadership and educational resources
- Need to implement career ladders and recognition for certifications
- Establish nurse "well-being" committees to protect the interests of the nurses while generating loyalty and confidence in the hospital

Ratios

- Change the "at all times" language in the nursing ratios law (N=5)
  - hospitals would have additional funds to retain existing staff
  - this is a killer
- Need a fair and impartial review of nursing ratios (N=2)
  - true evaluation of evidence-based impact of staffing ratios linked to "at all times"
- Re-address nurse-patient ratios
- Disallow dictated ratios and respect professional judgments for skill mix.
- The financial impact of ratios has caused a decrease in support from other hospital departments to offset the cost as all hospitals struggle financially while costs continue to climb and revenue decreases
- Need clarification from the BRN/DHS on ratio language which is used by unions to split staff and causes great misunderstanding and expectations that the law does not require
- Need a clearly defined process for meeting ratios while still working with LVNs to address issue of RNs only or application of ratios to include all licensed staff
- Need to recognize that ratios are not appropriate for small rural hospitals where acuity is very low—ratios should be acuity based
- Hospitals are more than willing to comply with ratios and always have been but ratios exemplify the "cart before the horse" analogy as the nursing shortage is the real issue
- Fund any additional staffing mandates

List F-1 (Continued):

Regulations/Legal Issues

- Make the regulatory standards related to clinical performance achievable rather than onerous (i.e., restraint use)
- Modify labor laws to allow more flexibility in shift scheduling (i.e., ability to mix 8-hour and 12-hour shift staff in the same unit which would work best for patient care but is not permitted).
- Need to be able to use grants/government funds in a public hospital for programs such as *Magnet* certification, stipends for students, or preceptor compensation to support efforts to provide quality care as well as a professional nursing environment
- Licensing for Critical Access Hospitals should come into alignment with the federal regulations for staffing
- Need alignment of state DHS requirements that are more consistent with validated acuity tools
- Decrease regulatory requirements related to documentation and the need to continually flex to accommodate regulatory compliance changes
- Streamline regulations between JCAHO and DHS
- Decrease reworking of the JCAHO standards

Staffing

- Need to develop a standardized acuity-based patient classification system to assist with staffing and prevent burnout
- Better interfacility cooperation and collaboration to optimize bed and staff use
- Review traditional hours which are not conducive to family schedules

Student Recruitment/Support

- Increase spending for programs that promote the nursing profession in high school (N=3)
  - also middle school
- Improve the image of nursing so that students will choose it as a profession
- Proposing that the hospital provide zero cost housing to students in hospital-owned homes in return for a commitment of service after graduation
- Offer tax benefits to those who choose nursing as a career and practice full or part time.
- Start promoting the nursing profession in the grade schools
- Focused recruitment of minorities and men
- Fund TV ads to promote nursing as a profession
- Need state-sponsored loans for RN students who work in underserved areas
- Have seen some success with the Boy Scout's RN Explorer program to interest 14 to 20–year olds in nursing

List F-2. Recommendations listed by respondents from skilled nursing facilities related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Boards of Nursing/Licensure

- Need a broader scope of practice for the LVN

Compensation

- Need better pay rates and good benefits (eg., affordable insurance, emphasis on retirement benefits) (N=10)
- Legislate pay raises/salaries for all licensed staff
- Too much compensation competition

Nursing Education

- Increase number of nursing schools/enrollments/graduates (N=7)
  - qualified students are unable to enroll
- Standardize nursing education--each school produces different results in the level of functioning so there is no predictability of ability with new grads and functioning on the floor is an issue even with orientation
- Need more focus on gerontology in medical and nursing schools throughout the country
- Educate nurses that supervising others is part of their job and is in the best interest of their patients

Organizational Culture

- Move to electronic records in long term care to allow more time on the floor
- Nursing workforce cut significantly with new change in ownership
- Need to change the public perception of long-term care
- Nurses need to have more choices

Overseas Recruitment

- Recruit more nurses from foreign countries (N=3)
- Provide grants and programs for foreign RNs to have financial support while going to school

Public Awareness

- Educate public about what nurses face in terms of legal issues, family , stress, patient acuity and workload

Ratios

- Long-term care needs staffing ratios/better staffing ratios (N=7)
- Ratios could improve job satisfaction but there is not enough money to pay for them or nurses to fill the positions even if the money would allow it

Regulations/Legal Issues

- Decrease paper compliance/documentation (N=7)
- Need to be able to use the medication nurse to decrease some of the workload on the RN
- Change the overtime laws so that overtime is not paid after 8 hours in a day but after 40 hours in a week

Staffing

- Nurses are not encouraged to work in long-term care and the demand is increasing
- Need more RNs in facility due to increased patient acuity

List F-2 (Continued):

Student Recruitment/Support

- Promote the nursing profession in high school (N=2)
  - also in community college
- Make financial aid more available to students
- Offer more incentives and moral support for non-RN employees to pursue nursing education
- Mentor LVNs to RN and provide flexible education hours to complete the course
- Need educational grants and scholarships

List F-3. Recommendations listed by respondents from public health agencies related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Boards of Nursing/Licensure

- Establish BSN entry into practice (N=2)
  - eliminate non-BSN programs
- PHNs should have master's degrees and be recognized as advanced practice nurses
- The state, including the BRN, need to take the crisis in public health seriously

Compensation

- The community and the state are dependent on a strong public health staff but do nothing to support it (e.g., no money to do recruitment, increase salaries, or provide incentives for retention)—need help from state funds
- Salaries for public health nurses must be competitive with other specialty areas and acute care

Interdisciplinary Relationships

- Change the MD curriculum to assure respect for other professions—MD disrespect of RNs is a problem

Legislation

- Stabilize funding for public health at the state level
- Grant funding for special projects creates loss of service at the end of the grant plus unstable funding for nurses

Nursing Education

- Increase the number of BSN/PHN program slots in the state (N=13)
  - provide incentives to the schools
- Strengthen the leadership component of the nursing curriculum (N=2)
- Need more nursing faculty (N=2)
  - cannot expand nursing workforce without addressing the acute shortage of faculty
  - need to recruit nurses into faculty roles
  - academic/service partnerships to address the faculty shortage
- Misconceptions about and little emphasis on the field of public health in nursing schools
- Require a public health rotation in university programs not just outpatient clinics or home health
- Require a second language in BSN programs
- Guest speakers from public health practice to expose students to the field and all of its diverse roles and activities
- Develop a track where ADN graduates with a BS in a related field can fast-track to get a PHN certificate, perhaps with some credit for experience
- More flexibility in advanced level studies to work around work and family responsibilities
- Raise the bar on nursing education entry criteria to foster competency, professional recognition
- Not having a college or university in the county is affects all areas of professional practice

Nursing Practice

- Adoption of the *Minnesota Model for Public Health Nursing* is likely to attract nurses interested in Public Health

Professional Growth/Support

- Need transitional programs for nurses from other settings who want to work in public health
- Need training programs for job change/advancement within the field of public health

List F-3 (Continued):

Public Awareness

- Need media promotion of public health nursing

Staffing

- Shortened length of stay due to insurance requirements has increased acuity and decreased time to treat/care for patients
- Need bilingual/bicultural staff

Student Recruitment/Support

- Recruitment and support for students from diverse cultural/language populations

List F-4. Recommendations listed by respondents from home health agencies related to recruitment and retention of RNs. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Boards of Nursing/Licensure

- The U.S. must allow qualified RNs from other countries to work—the Board should expedite process of the examination and issuing a work permit
- Make it easier for international nurses to come to the U.S.

Compensation

- Decrease workers compensation rates so more revenue can to higher wages and insurance coverage for employees
- Increased compensation would make it easier for nurses to perform regulatory tasks unique to homecare for which agencies are not paid
- Increase compensation in home health
- Must ensure that RNs feel valued, appreciated and are fairly compensated
- Good retirement benefits

Hiring Issues

- The county needs to address the high cost of housing
- Providers are not protected with a very mobile workforce

Nursing Education

- Increase the number of nursing programs (N=6)
- Fund nursing schools to increase enrollments/graduates (N=4)
  - qualified applicants being turned away
- Increase the number of BSN graduates (N=3)
  - do not increase numbers of ADN graduates just because there is a shortage
- More LVN-to-RN programs (N=3)
  - with scholarships
  - funded by the state or federal government so that the LVN can receive a salary while attending school for one year to be ready for the Board exam
- Increase pay for nursing instructors (N=2)
- Re-institute hospital-based nursing programs
- Partnerships between educational programs and employers to assist in the career ladder program and recruitment of qualified personnel
- Do not lower program standards—too many in nursing just for the money
- Need better training and experience in home care so that nurses consider home care as an option
- Suggest DHS create a centralized home care program to prepare new graduates for home care without hospital experience

Organizational Culture

- Communication is paramount– nurses need to feel appreciated and respected and kept in the loop
- No longer see the draw to home care—there is more autonomy and non-shift work, but the stressors are still there in a different form
- Allow personal time off

Professional Growth/Support

- Nurses need to have more choices
- More support for RNs

List F-4 (Continued):

Reimbursement/Regulations

- Reduce paperwork/documentation requirements (N=4)
  - so nurses can take care of people
  - much is repetitive and not related to patient care
  - more time spent complying with regulations than doing patient care
  - hand-held device software could ease burdensome paperwork
- Increase state-allowed billing rates (N=2)
  - to increase salaries
- Current regulations identify too much care of people asoverutilization, or too little care, which keeps people from getting the care they need
- Changes in reimbursement are problematic
- Fears related to the reimbursement environment seem to be plaguing hospital administration but they need to stop so that administration does not make nursing the scapegoat
- Medicare needs to see home health as a viable and affordable option rather than treating home health punitively
- Get rid of OASIS

Staffing

- Eliminating LVNs because RNs still must oversee and countersign their work
- Retirement will create challenges
- Trying to use more LVNs to help out but need more RNs

Student Recruitment/Support

- Promote the nursing profession in middle school (e.g., like the *Junior Ranger Medic* program)
- Encourage high school graduates to major in nursing
- Promote the nursing profession as a career choice like the career of teaching has been promoted
- Provide tuition reimbursement to RNs willing to work for two years in an underserved community
- Financial assistance for BSN to MSN education
- Recruit non-RN health care workers into nursing
- Provide preceptorships and stipends to anyone interested in entering nursing

Appendix G
Resources

List G-1. Resources listed by respondents from hospitals. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Resources for Hospitals

- Federal grants specifically designed for public hospital use
- Increased hospital reimbursement from Medicare and HMOs
- Payers of healthcare should pay for quality with nursing care as a reimbursable item
- Community outreach programs from other institutions
- Federal government should re-institute outlier payments since only one organization was abusing the system and all are paying the cost
- State government needs to lessen the unfunded mandates
- The public needs to be aware of the implications of the nursing shortage and help financially

Resources for Non-Hospital Initiatives

- State government (N=9)
  - grants to nursing schools
  - a State Bond Initiative dedicated to nursing education might be successful and raise public awareness about the need for nurses
  - subsidy to all schools to produce more nurses not tied to service in underserved areas
- Federal funding (N=5)
- Grant funding opportunities including grants from foundations (N=5)
- Hospitals should contribute to nursing schools (N=4)
  - have supported schools to take in more students
  - industry partnerships with schools
- Local community funding
- Work force initiative grant funds
- Endowments
- More colleges need to make the commitment to nursing education
- Private individuals through a non-profit organization
- TELACU for assistance to Hispanic students
- State-sponsored loans to students
- Company sponsorship promotions of nursing as a career (e.g., Johnson & Johnson)
- Unions should contribute

List G-2. Resources listed by respondents from skilled nursing facilities. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Resources for Skilled Nursing Facilities

- MediCal and Medicare need to increase reimbursement (N=6)
- Forgive portion of student loan for work in skilled nursing facility

Resources for Non-Facility Initiatives

- State/Federal government (N=6)
  - government grants to schools
- Workplace sponsorship in return for workplace commitment
- Hospitals and skilled nursing facilities
- Chamber of commerce
- Churches
- CAHF

List G-3. Resources listed by respondents from public health agencies. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Resources for Public Health Agencies

- Set aside some of the nurse scholarship and grant funding for public health
- Need a state nursing director to advocate for public health at the state level
- Stabilize source of funding to prevent competition with other good causes, such as fireprotection

Resources for Non-Agency Initiatives

- State government (N=2)
  - reallocate existing monies from non-growth education areas to nursing
- Federal funding
- CCLHDND to take leadership

List G-4. Resources listed by respondents from home health agencies. Each comment was listed by a single respondent unless the number of respondents (N) providing similar information is noted at the end of the item. Multiple comments from individual respondents may be included.

Resources for Home Health Agencies

- Increase MediCal and Medicare reimbursements (N=3)
- Increase PPS reimbursement to rural home care agencies
- Increase reimbursements from private insurers

Resources for Non-Agency Initiatives

- State funding (N=2)
- Federal funding (N=3)
  - reallocation of funds obtained by cutting overhead at HCFA and Social Security
  - federal loans cancelable with each year of service
- The drug industry might be a resource
- Offer forgivable loans for MSN programs to produce more teachers
- Increase the RN license fee and get support from corporations toward a fund to support individuals interested in going into nursing

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